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REDEFINING THE PRISON MILIEU

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ARC505 THESIS PREPARATION

FALL 2014

“Despite a personal revulsion, we think of [asylums] as always having been with us. We tend to forget that they were the invention of one generation to serve very special needs, not the only possible reaction to social problems. In fact, since the Progressive era, we have been gradually escaping from institutional responses, and one can foresee the period when incarceration will be used still more rarely than it is today. In this sense the story of the origins of the asylum is liberating. We need not remain trapped in inherited answers. An awareness of the causes and implications of past choices should encourage us to a greater experimentation with our own solutions.”

David J. Rothman

The Discovery of The Asylum: Social Order and Disorder in the New Republic, 1971

Emily Lodato
Professor Lawrence Davis
Professor Amber Bartosh, Professor Greg Corso
ARC505 Thesis Preparation
Fall 2014

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l.

Prison should aspire to become a place for the promotion of mental health as a positive state; a place lessening the risk of deterioration of mental health through high-quality care and environment for inmates to thrive.¹ The basis of prison design should be a therapeutic community.

In order to design for reform, the design must begin by bringing back the basic human needs of the inmates. It will begin with a plan of a community configuration that promotes social interaction; the aspect of treatment will be inserted, imposing a program that requires effective communication between inmates. Finally, the need for security will work its way through the organization of the private and public spaces in order to maintain safety. The overall design producing a high level of containment remains and exists as the element of punishment through the loss of personal freedoms.

Spaces of solitary confinement and isolation are the most detrimental to the mental health of any patient. In order to influence positive mental health, spaces must promote human interaction with the objective of instilling a sense of community in the inmates. A community is composed of varying architectural elements that create private and public spaces with different types of restrictions at different times.

¹ Fraser, Gatherer, and Hayton, "Mental health in prisons: great difficulties but are there opportunities?" *Health & Place* 123 (2009): 412.

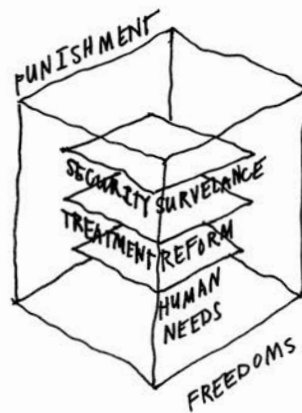
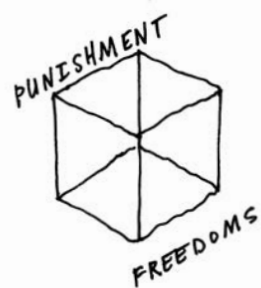
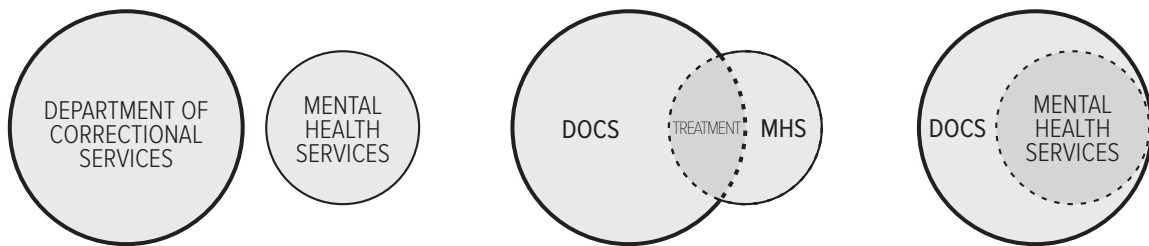


Figure 1.1



The original condition.

The current condition.

The future condition in prison.

This image shows the merging of the DOCS and MHS systems in prison: the original separate condition, the current merging condition and the future encompassing condition.

Figure 1.2

The evolution of the relationship between the Department of Correctional Services and the Mental Health Services represents the development of mental health care in penal architecture. The original condition was nonexistent; there were prisons and asylums, and they intended to house different kinds of people. With the realization that mental illnesses could not be cured came the mass institutionalization of all society's disruptive persons. The current condition is described as the MHS breaking through the DOCS system; the post-deinstitutionalization movement has forced the two systems to merge.²

Today, mental health practices are being brought into prisons in the form of treatment programs run by professionally-trained staff. Unfortunately, treatment cannot be achieved without proper spaces for scheduled programs as well as spaces for inmates to implement their lessons. The ideal system would be a prison that begins with mental health practice implemented into all aspects of the prison milieu. This would mean that the design of prisons should model a community with overlapping constraints, or security.

² Becher, Xenia, by Emily Lodato, November 11, 2014.

The rehabilitation aspect of the prison looks to define three main aspects: daily regimen, social interactions, and self-reflection and reformation.

The typical penal facility is organized according to security, circulation and design by function. In order to make it easier for staff to observe inmates, functional spaces are clustered. Since the inmates follow the same schedule, the inmates and staff would generally be located in one, highly-secure space.

By redirecting the design and organization effort as a set for social interactions, the inmates can circulate through the prison almost as a civilian would through a city. In order for staff to facilitate proper social work, the group spaces will accommodate no more than 24 inmates. That leaves the option to formulate clusters of 24 inmates that can join together or exist individually. An opposition to this would be to continue to group the spaces by function, mimicking a traditional penal plan.

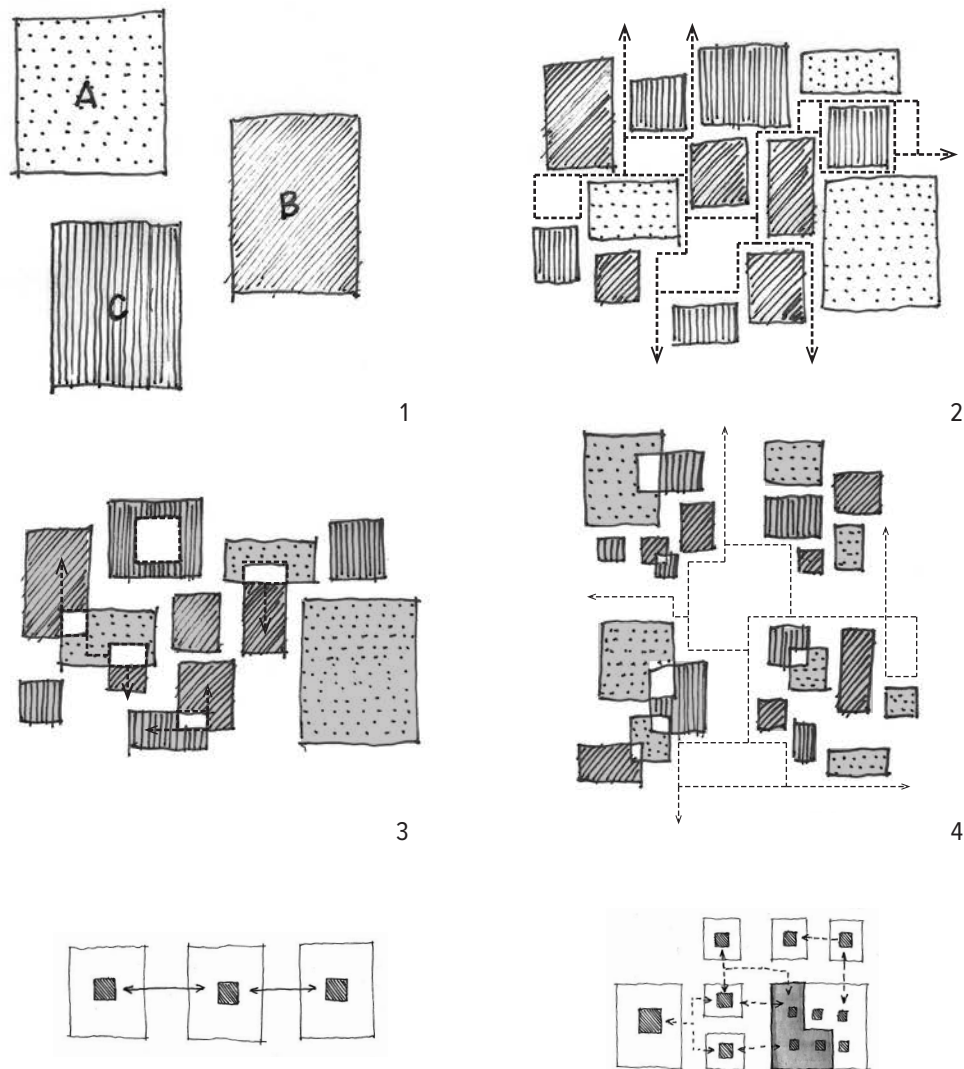
The inmates will follow a daily routine that includes spaces for self-reflection and group activity. Ideally, they will perform their

activities within their clusters in order to develop relationships with each other and staff; however, privacy and space for individual time is important.

The various individual and group functions should coexist. Functions enrich the plan, and when combined create new freedoms through the shuffled order based on the interconnection of spaces and close-knit patterns of association.³ Individual spaces should be within close proximity to group spaces to allow inmates to move freely, as demonstrated by the mat building typology.

To grant inmates with the freedom to transition from one functional space to the next poses a potential breach in security. The smaller clusters minimize this breach by creating fewer voids in between functions and less paths traveled by inmates. Therefore, the clusters are the most effective way to combine the various programs of the prison with different spatial intentions.

³ Mahnaz Shah, *Le Corbusier's Venice Hospital Project: An Investigation into Its Structural Formulation*, (Farnham, Surrey: Ashgate Publishing Limited, 2013), 135.



Blocks A, B and C each represent spaces specified by one function. In the first configuration each function stands alone. In the second, the spaces are broken down into multiple smaller spaces of one function, creating new interactive voids. The third configuration overlaps the functions to create new functional spaces within those existing. Finally, the overlapping, functional spaces and voids are divided into separate microcosms connected by the larger voids between them. This creates multiple, intersecting circulations as opposed to one linear, repetitive sequence.

Figure 1.3

Human interactions include contact between inmates and inmates and staff.

Direct interactions constitute an exchange of looks paired with body language and/or physical contact.

Indirect interactions are only defined by visual contact.

Nonexistent interactions consist of an inmate in a solitary space.

A variety of interactions requires a variety of spaces. By creating a routine for the inmates to follow, it assigns inmates to inhabit multiple spaces through the course of one day and enforces interactions and encounters for inmates.

Reform provides opportunity for the inmate to decide his type of interaction. As opposed to creating different spaces for stages of rehabilitation, an inmate's progression should be rewarded with the ability to select the space he wants to be in during his designated daily treatment time. Part of learning to live outside prison again is coping with the return of freedoms.

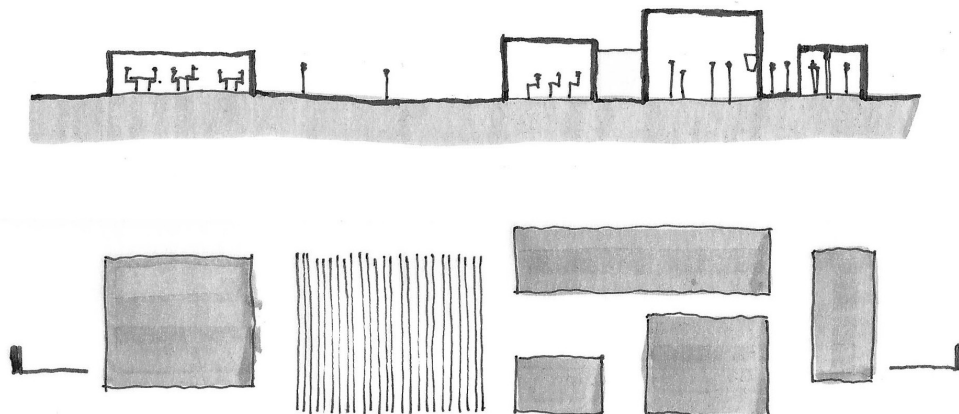
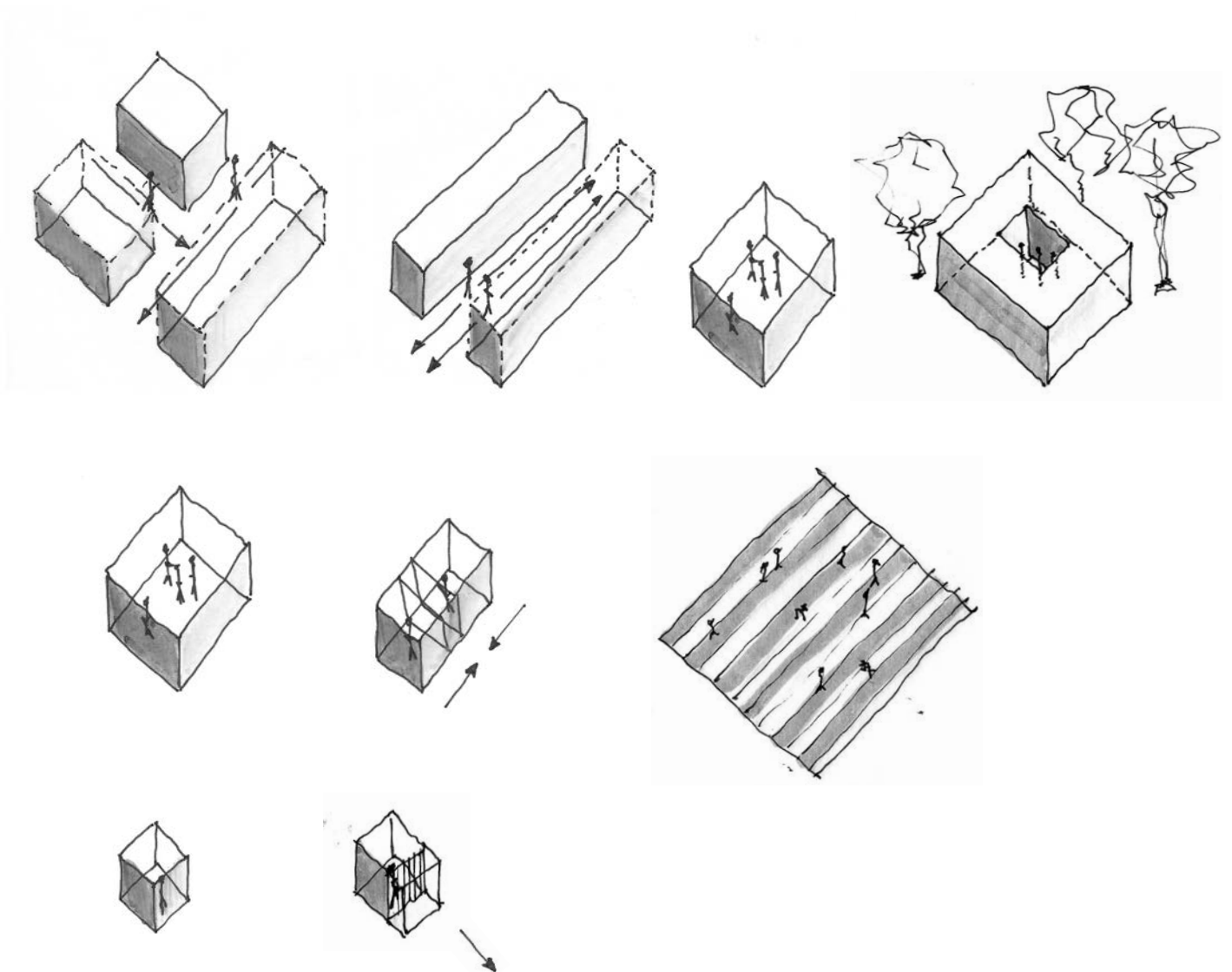


Figure 1.4



DIRECT HUMAN INTERACTIONS
crossing paths, synchronized paths, conversing

INDIRECT HUMAN INTERACTIONS
being together, being watched

NONEXISTENT HUMAN INTERACTIONS
being alone

Figure 1.5

II.

The typical prison configuration is designed to produce a system of containment, punishment, while removing our existing freedoms. In doing so, all traditional aspects of human life are forgotten. This begins with surveillance and security. The best example of this is the panopticon.

Jeremy Bentham's concept for the panopticon was designed in order to provide maximum surveillance with a single watchman. The inmates are contained in a multilevel, cylindrical building with cells lining the inside perimeter of the exterior masonry wall. The watchman is located in the center of the space on the ground floor. The design is dictated by providing the watchman with a 360-degree view of the inmates.

The design for reform is based on interactions: with the surrounding environment, nature, people, objects. Each of these aspects influences the mental health of the inmates and the panoptical approach to prison design seeks to limit and remove them. The ideal prison design is not the panopticon; the anti-panopticon.

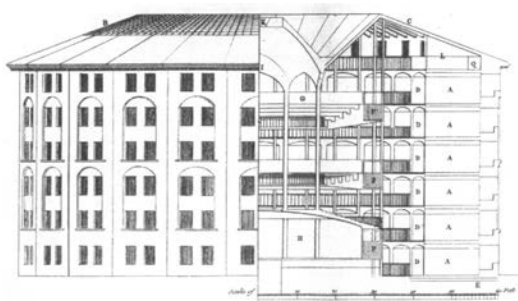


Figure 2.1

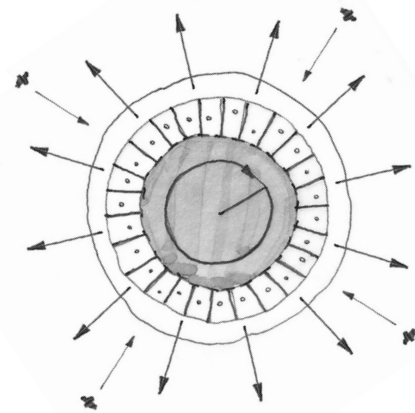
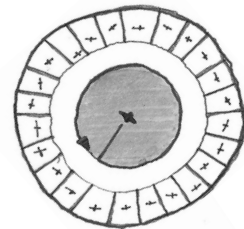
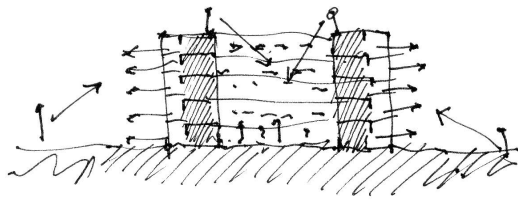


Figure 2.2

III.

David J. Rothman's *The Discovery of the Asylum: Social Order and Disorder in the New Republic* explores the intentions of the nineteenth century asylum: design not to mimic prisons and almshouses, separate the insane from the community, and control patients by implementing regimen and routine known as moral treatment. The idea was to keep patients busy with manual household tasks or chores and maintain a silent environment. This resulted in a building design consisting of symmetry as the basis for regular routine. Each ward would be composed of a parlor, corridor, an associated dormitory, clothes room, bath room, water closet, speaking tube and dumb waiter. Patients were to be classified by behavior: the quiet and patient versus the noisy and violent. The patients would be placed in different buildings or wards dependent on their classification.⁴ The treatment of the patients was imbedded in the architecture of the building, which could infer that the design of the building was not adequate for its intended use.

⁴ David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little, Brown and Company, 1971) 269.

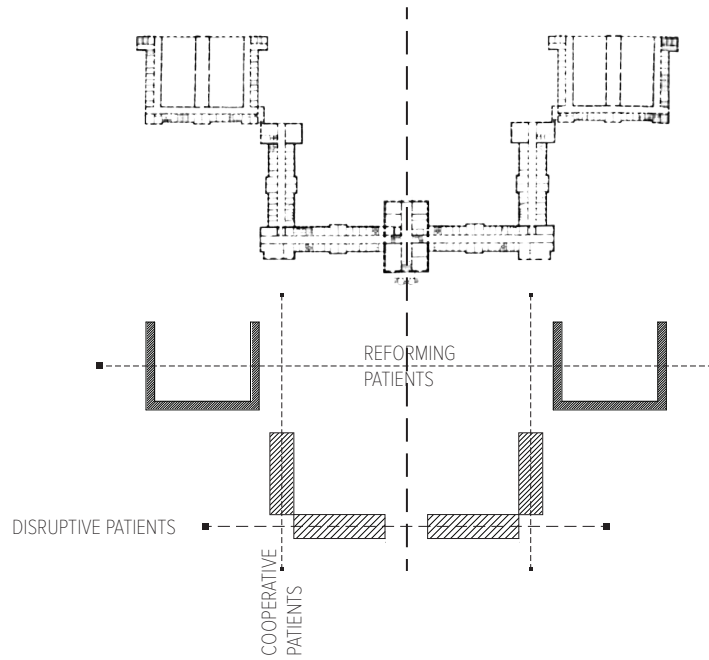


Figure 3.1

The Pennsylvania Hospital for the Insane demonstrates the importance of uniformity and regularity in the treatment of the insane through the attempted classification of patients.

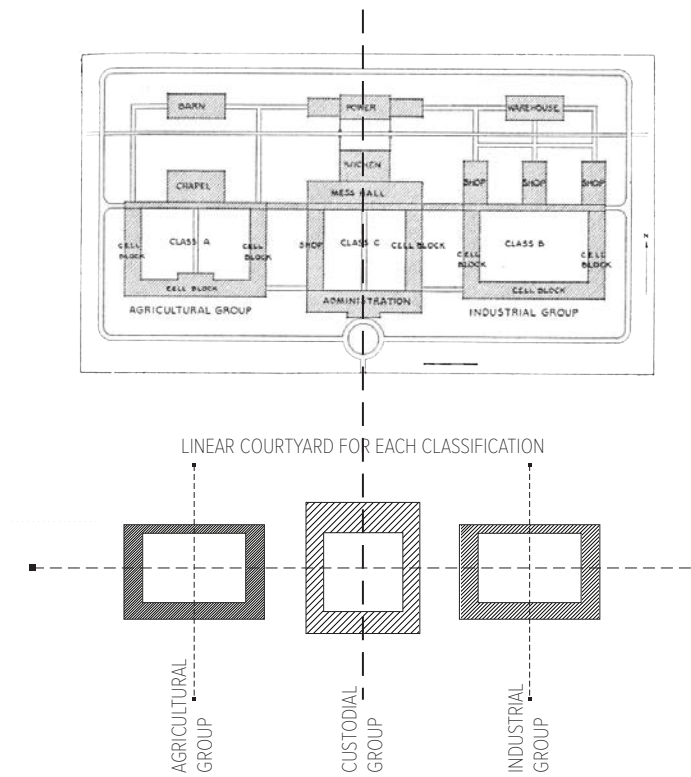


Figure 3.2

An early plan of a penitentiary classifying three activity groups in order to put cooperative inmates to work will centrally monitoring high-security prisoners.

Rothman continues to describe the post-1850 asylums as overcrowded, lacking patient-classification and ceasing work therapy with the addition of mechanical systems and harsh punishments including straitjackets, cuffs, sleeves, bedstraps and cribs. As the hope of rehabilitation began to fade, asylum superintendents began performing custodial operations to detain the patients. In opposition, neurologist William Hammond declared the mentally deranged would be best cared for in the home and that an institutional environment neglected familial interactions and contrarily provided an association with insanity of varying degrees. This is contingent of safety and the behavioral classification of the patient.⁵ It would be considered unethical to endanger the family of a violent patient and would ultimately result in the strict punishment of that

patient.

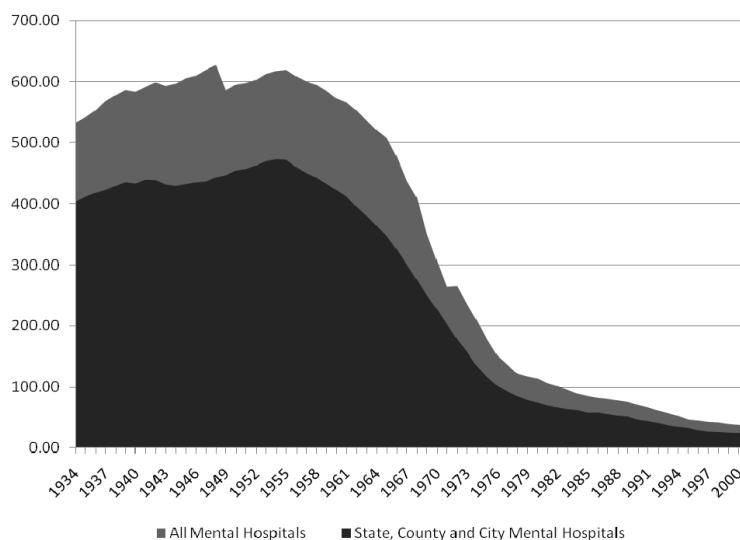
After the realization that there was no determined cure for the insane, asylums, similar to prisons and almshouses, became a mere shield for unwanted persons from society, and by the time of the Civil War all poor people were living in places with inadequate treatment for their attendance. By the year 1955, the institutionalization of mentally ill persons peaked at 560,000; this was the beginning of the deinstitutionalization movement.⁶ While the number of psychiatric hospitals has decreased to approximately 50,000 today, there are 500,000 incarcerated persons suffering from mental disabilities.⁷ Due to the growing population in the United States, the effects of deinstitutionalization in the twentieth century does not concur with the amount of institutionalized mentally ill in the country. However, this data supports the belief that

⁵ David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little, Brown and Company, 1971) 269.

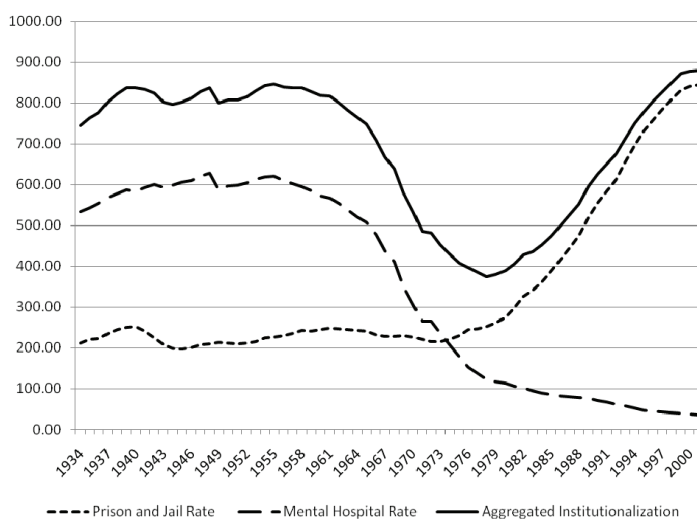
⁶ Bernard E. Harcourt, "Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s," *Ohio State Journal of Criminal Law* 9, no. 1 (2011): 64.

⁷ *The New Asylums*, directed by Miri Navasky and Karen O'Connor (2005; Boston, FRONTLINE), online.

Different Rates of Institutionalization in Mental Institutions in the United States (per 100,000 adults)



Rates of Institutionalization in Mental Institutions and State and Federal Prisons (per 100,000 adults)



Rates of Institutionalization in the United States (including jail populations)

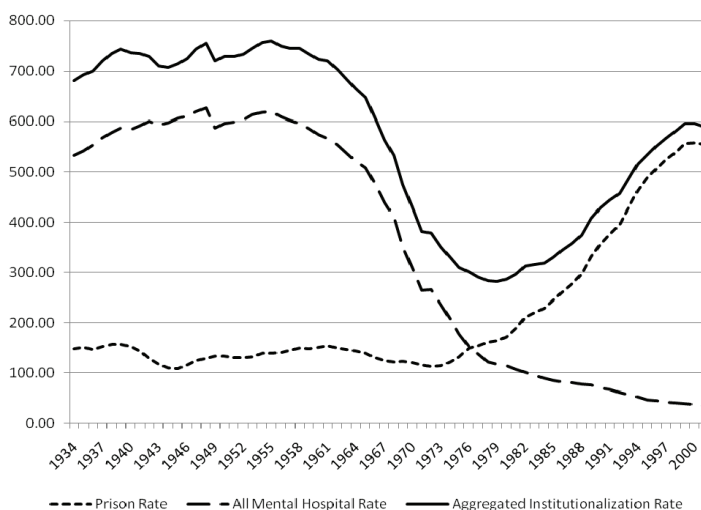
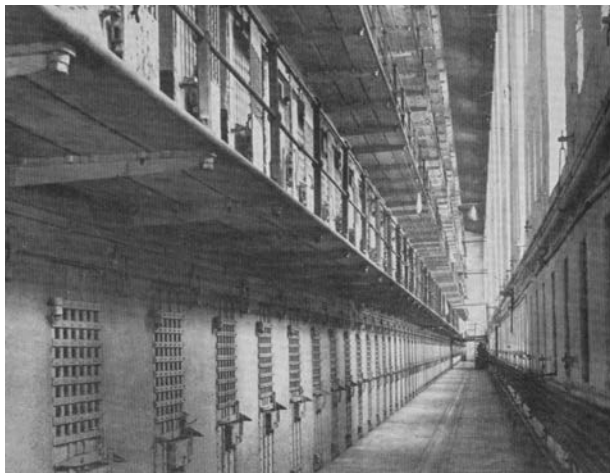
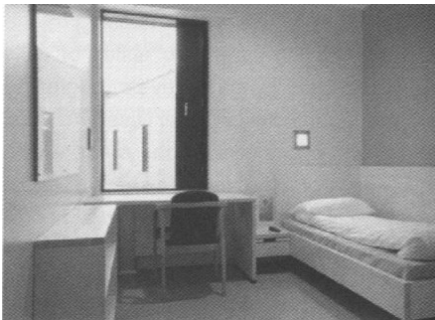
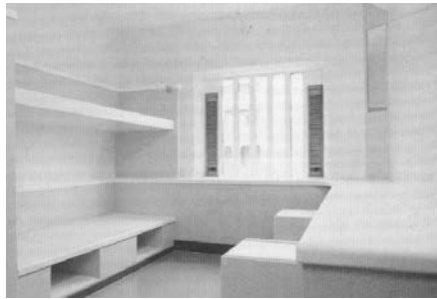
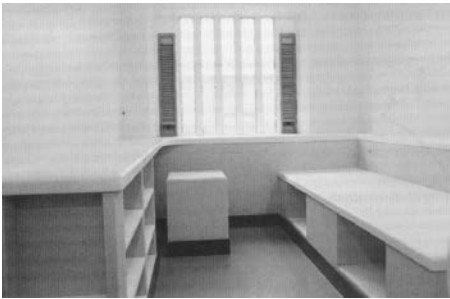


Figure 3.3



From left to right, Figures 3.4 through 3.12

The de-emphasis on public mental health policy in the 1980's was the start of the decline of mental health hospitals and asylums and the spike of mental health inmates in prisons. Jeff Goodale explains jails and prisons are acting as mental health facilities. The architecture of prisons is beginning to incorporate the original objectives of the asylums with an emphasis on recovery over custody. To foster the rehabilitation of inmates, Goodale proposes normalizing the prison environment with a relation to residencies and connection to the outdoors: larger windows, wood doors, more normal furniture and carpeting. In addition, the creation of rehabilitative programmatic spaces for education, treatment and counselling.⁸ Similarly, as with the design for asylums, the architecture of the prison is intended to rehabilitate the inmates. Regarding the inmates

suffering from mental illness, these types of spaces are essential for patient treatment, in addition to properly prescribed and administered medication. Fred Cohen describes the spaces of confinement and segregation in which mentally ill inmates are often placed in, after acting out as a result of their condition, are detrimental to their recovery, as they are for any prisoner. Instead of providing transitional treatment spaces and hospital spaces, these inmates are deprived of proper sleeping quarters and medical care. Cohen also raises a concern with the result of facilitated treatment for mentally ill inmates in prisons, as it insures the rethinking of institutionalization as a treatment and further investigates the insertion of an additional program for prisons. He concludes that while he is extending the life of the flawed prison system, any steps towards reform should be taken.⁹

⁸ Jeff Goodale, *Prisons* by CLOG. February 6, 2014.

⁹ Fred Cohen, *Frontline*, December 2, 2004.

Relatively compared to most structures built in the United States, correctional facilities were built to last.¹⁰ The history of prisons and asylums in the United States began with new construction, as opposed to those in Europe that were repurposed monasteries and castles from centuries prior. When a building is constructed of materials with a low degree of deconstructability to withstand time, it would ideally consider a level of adaptability as well. Without the ability to change over time, many correctional buildings have become obsolete in their intended attendance. Many institutions have closed within the past few decades and are just beginning to be repurposed and restored, mostly as museums in addition to providing other land uses. With approximately 2.3 million incarcerated persons in the country, the construction of prisons and jails in the United States has continued through the incorporation of rehabilitation in design.¹¹ Since these buildings are mostly made possible through government funding of the criminal justice system, the rethinking of build-to-last and sustainable construction should coincide with the changing methods of care for the mentally ill.

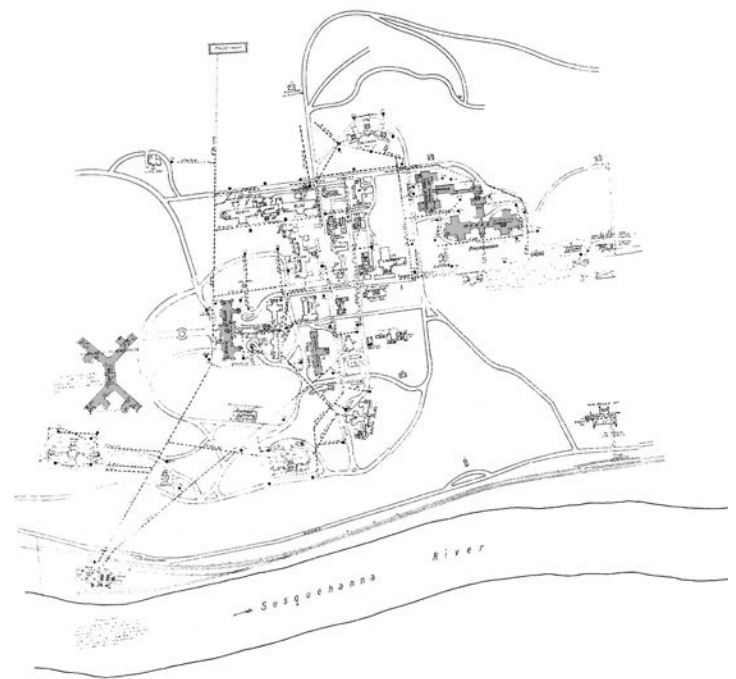


Figure 3.13

Plan of the Binghamton State Hospital for the Insane from 1918 highlighting the remaining existing buildings that have been repurposed for administrative purposes in corrections.

¹⁰ Brian Pagnotta, "Allegheny County Courthouse and Jail: Adaptive Reuse," *Prisons*, (2014), 146-147.

¹¹ *Prison State*, directed by Dan Edge (2014; Boston, WGBH Educational Foundation), online.

Being that his book was published in 1971, Rothman concludes that, despite the use of pharmaceuticals as the potential-cure, institutionalization is still a response to mental health illnesses. While expressing his discontent with contemporary efforts of change he states, "Proposals that promise the most grandiose consequences often legitimate the most unsatisfactory developments".¹² Similarly to what Gary Wolf notes, this statement is relevant now, just as it was then, in relation to the disappointing design of mental healthcare facilities. In order to provide adequate care, change must begin to create differences in the treatment of inmates suffering from mental illness by pushing the limits of architecture.

¹² Gary Wolf, "Limits of Architecture," *Prisons*, (2014), 20-21.

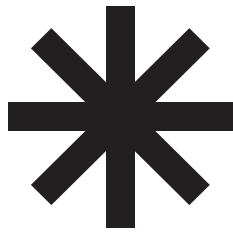
IV.

PENAL TYPOLOGIES AND PRECEDENTS



RECTANGLE

The rectangular scheme became known as the “Auburn” or “silent” scheme by limiting inmate contact as much as possible. The cellblocks are stacked vertically and arranged back to back with no direct windows to the exterior; the cells are accessed through long, adjacent balconies that overlook a corridor parallel to an exterior wall.



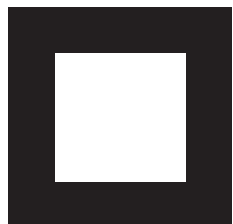
RADIAL

Designed around a central rotunda, this prison plan consists of “spokes” or wings of cellblocks; additional prison programs can be within the different wings or as separate structures located in between wings or adjacent to the entire complex. This scheme may include a perimeter to allow for free movement from one building to another.



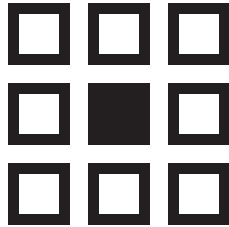
TELEPHONE POLE

A plan developed by the circulation of security, which includes a building with a central spine, a long central corridor or “pole,” crossed at regular intervals by structures containing inmates’ functional areas; this fosters continuous surveillance as well as independently controlled access to each functional area. Similarly to the radial scheme, this plan may include a perimeter to allow for free movement by inmates.



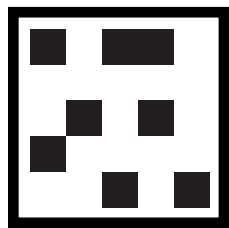
COURTYARD

With the intention of creating an optimal 360-degree view of inmates and allowing for the free movement of prisoners, this plan contains the inmates within an exterior courtyard by designing the functional units as all sides of the perimeter. The courtyard becomes a central circulation space as well as an additional functional space.



URBAN

A scheme where the correctional facility becomes a solid mas within the varying open and closed spaces of the urban fabric, mimicking its intention of the containment of prisoners in order to protect the general public. Despite its containment, an urban site creates more visiting opportunities for inmates.



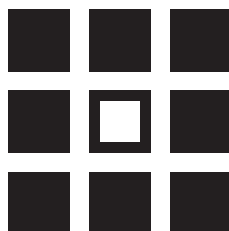
CAMPUS

A design by which the functional units are individually housed and organized according to any desired circulation. The scheme includes a perimeter to allow for the movement from one building to another without a risk of escape.



HYBRID / *URBAN + COURTYARD*

The hybrid combines the containment aspect of an urban prison with the plan of a courtyard scheme. Differently, the courtyard is not used as a circulation space; the circulation solely exists at the vertical cores each pertaining to one side of the program-embedded perimeter. The courtyard acts as a functional space, with 360-degree security.



HYBRID / *URBAN + CAMPUS*

The interjection of a self-contained microcosm within a larger, expanding city; the insertion of a campus plan within an existing urban fabric. While the two coexist, they each function separately according to their definitions; only are they together as places to travel to with intentions.

AUBURN CORRECTIONAL FACILITY

Auburn, NY

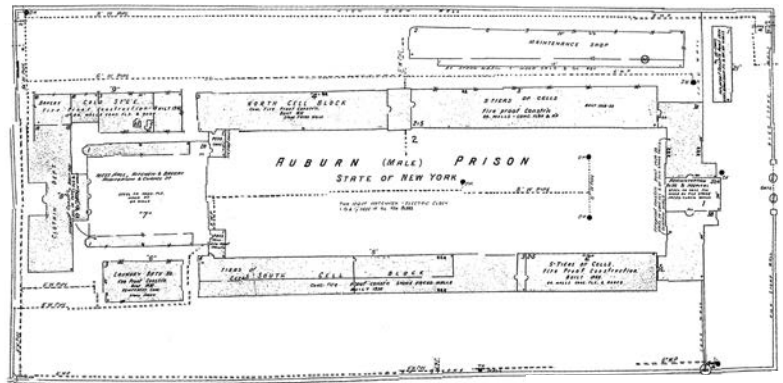
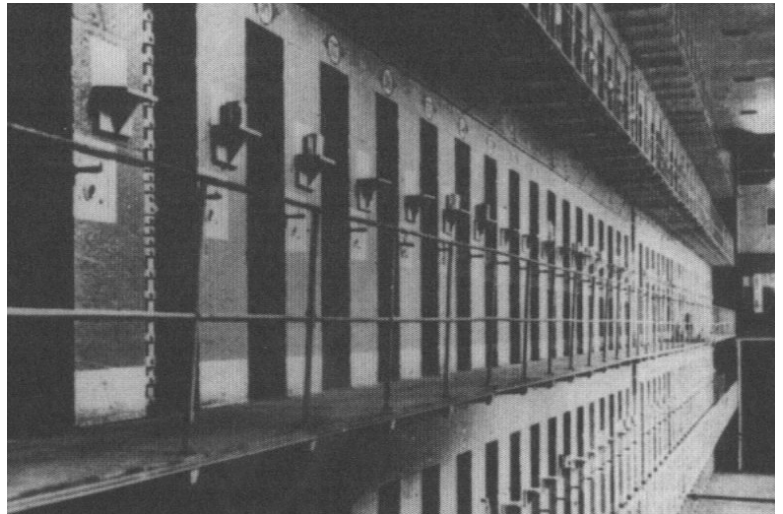
1816 Jonathan Daniels (south wing) and William Brittin, John Cray & Louis Dwight (north wing)

The "Congregate" system began at Auburn prison, which was defined by inmate work in association but complete silence during the day and solitary confinement at night; it became known as the "Auburn" system.

The design of the 7'-6" by 3'-8" cells reflects the silent, solitary system. The cells are arranged in rows back to back on five tiers in the long building. The cells were accessed on each level via a three-foot wide balcony that faced the exterior wall of the cellblock.

The south wing received an additional five tiers of cells in 1835, while the existing older cells were demolished to create space for a mess hall and other facilities.

William Brittin was direct to design the north wing of the prison for solitary confinement, but was stopped in 1824 due to the high rate of insanity and illness among the prisoners confined to the tiny cells.



Figures 4.1 and 4.2

SING SING PRISON FACILITY

Ossening, NY

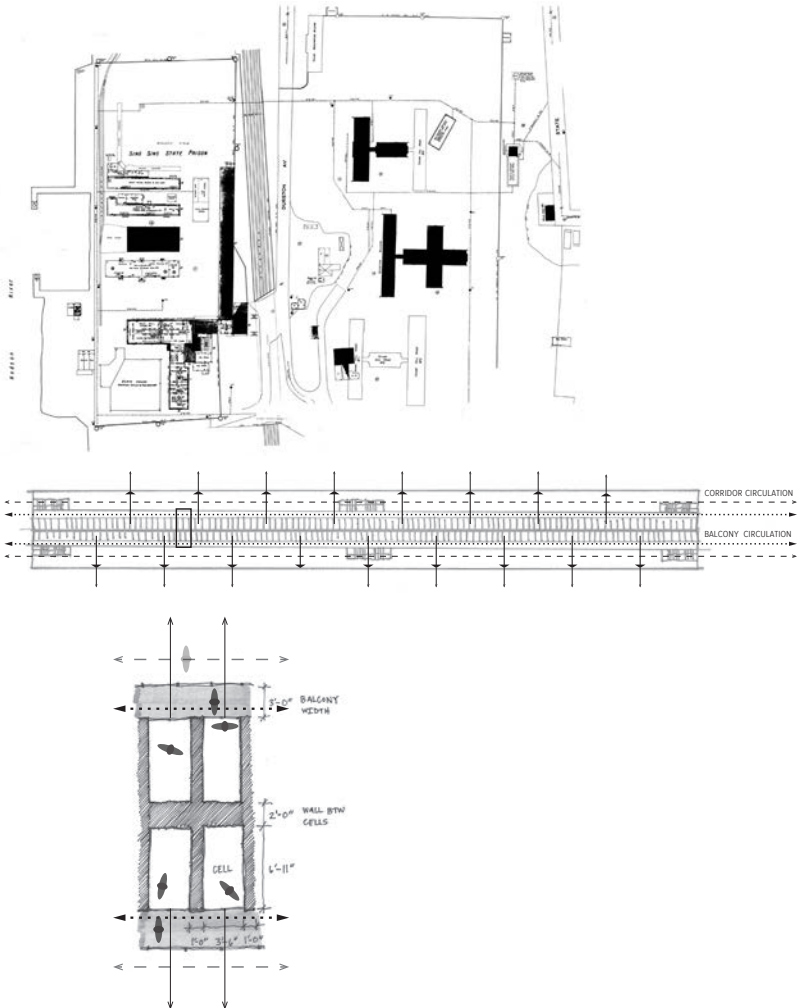
1825

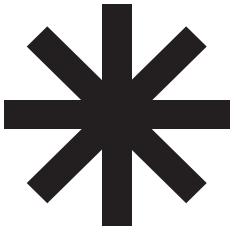
The Sing Sing Prison Facility was created to relieve Auburn Prison of its large abundance of inmates, ultimately resulting in overcrowding. It was designed to mimic the "Auburn" system.

Unlike the cell doors at Auburn Prison, the iron, grillwork doors at Sing Sing Prison were not recessed and allowed for more inmate interactions. Each cell had a view of a small window on the exterior cellblock wall that provided very little light to the tiny cell space.

The corridor was 476 feet long with approximately 105 cells on either side of the center in the cellblock rectangle. The balcony brought the staff in close contact with the inmates while the main corridor did so with only the ground level. The balcony ensured that while in his cell, no inmate would be able to escape to the exterior; *could this typology allow for larger windows and natural ventilation while maintaining high security?*

Figures 4.3 through 4.5





PENTONVILLE PRISON

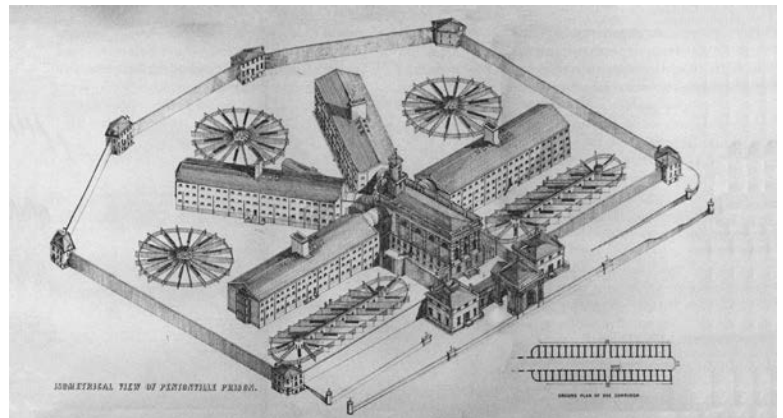
London, UK

1844 Joshua Jebb

The prison was designed to contain an inmate within his cell for sleeping and working. The careful design of sewage and ventilation pipes, in order to reduce the risk of escape was a key factor that set this design apart from those of its time.

Each wing had three levels of the cells facing the corridor; windows did not permit views outward and doors were solid with the exception of an inspection peephole. Exercise, education and religious services were designed to avoid inmate contact. Three circular structures were located between the radiating cell wings, each with a center inspection cubical for a guard and partitions for inmates.

Figure 4.6



EASTERN STATE PENITENTIARY

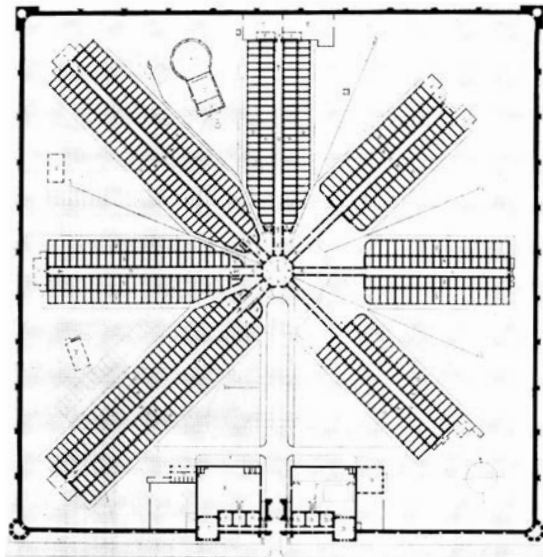
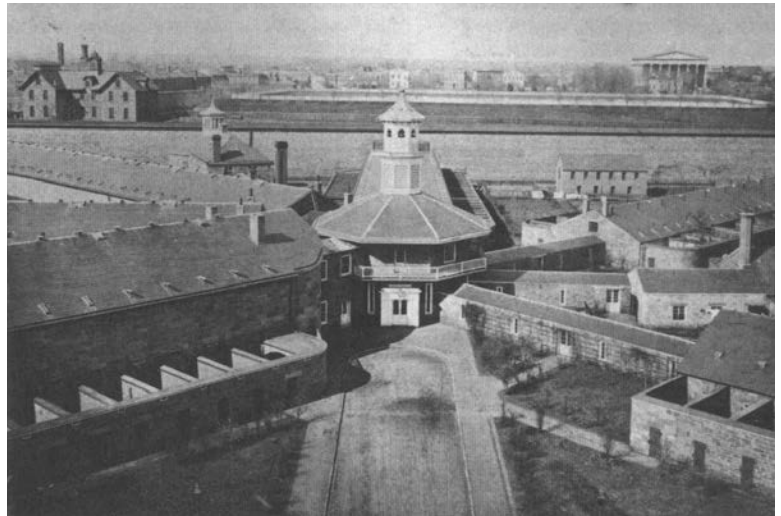
Philadelphia, PA
1871 John Haviland and William Strickland

The plan includes seven cellblocks radiating from a central rotunda on 409,600 sq. ft. of land all surrounded by a walled perimeter, only having one entrance to reduce the risk of escape.

At the entrance, and incorporated into the wall, is a two-story building to maintain the circulation moving in and out of the complex. It housed the warden's and principal keeper's apartments and offices; staff service facilities were located in the basement to distance the staff and inmates as much as possible.

The individual cells were lit by small skylights in the arched ceiling and peepholes were the only openings in the doors. Each cell opened onto an individual, walled exercise yard; this allowed each inmate to work, exercise and sleep in complete solitude.

Figures 4.7 and 4.8





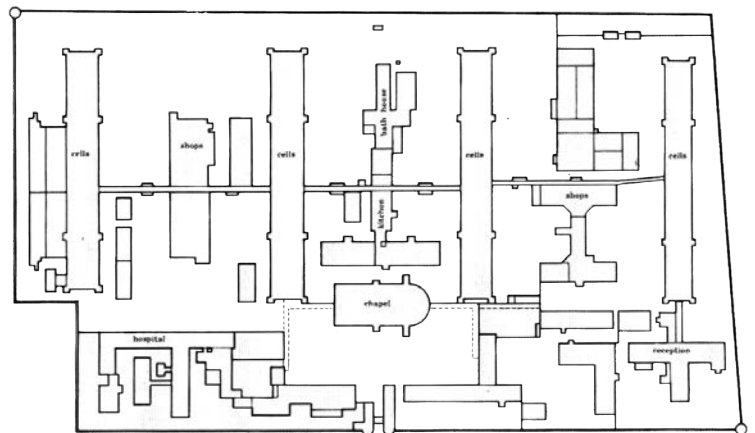
WORMWOOD SCRUBS PRISON

Her Majesty Prison Service
London, UK
1874 Sir Edmund DuCane

This prison was designed as an alternative to the radial scheme of the Pentonville prison. The plan consists of four parallel cell blocks connected by a roofed arcade, passageway.

Other programs such as, shops, chapel, hospital, and other service facilities are located off the blocks. The blocks are connected by a single, perpendicular corridor allowing staff to manage inmates' movements easily. The design allows for optimal sunlight and the avoidance of dark corners and courts. Each cell window looks out onto the exterior space designated for the individual block's use.

Figures 4.9 and 4.10

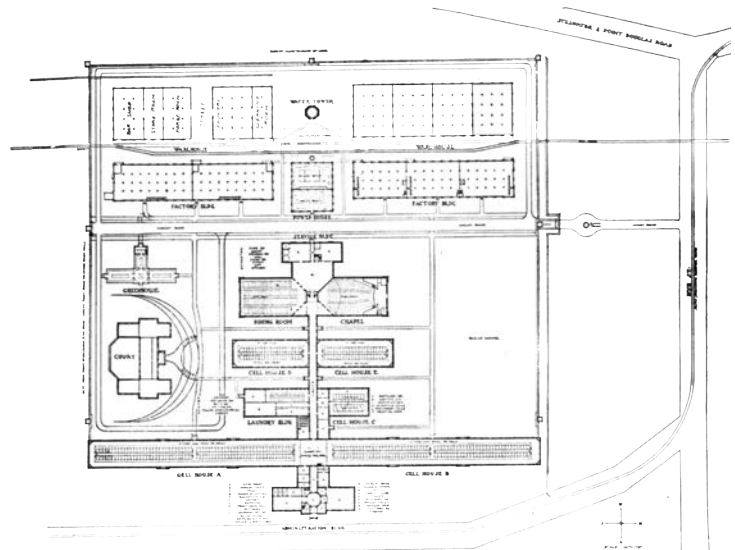


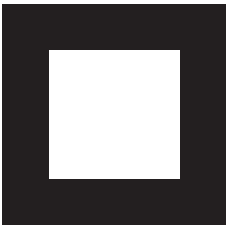
MINNESOTA STATE PRISON

Stillwater, MN
1914

This was the first United States prison to use the spine corridor connecting cellblocks and various services. The cellblock corridors appear to be flanking at one end of the spine while dining and religious spaces do the same at the opposite end. The administration building and service building cap either end of the spine for security and surveillance purposes.

Figures 4.11 and 4.12



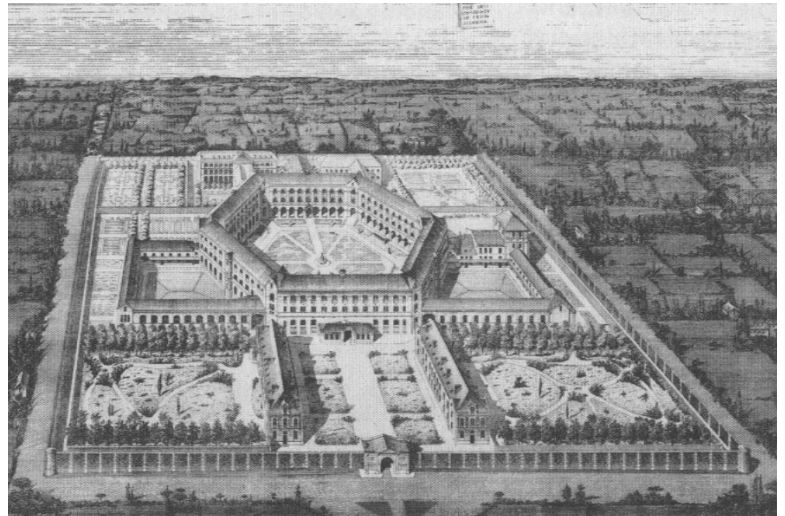


PRISON CENTRAL DE RENNES

Rennes, FR
1877 Alfred Normand

This building was one of few in Western Europe designed for its function during the 19th century. The prison consisted of multiple groups of three-story buildings forming an octagonal inner court. Communal-activity facilities were located on the ground floor and opened onto arcades with dormitories above.

Figure 4.13

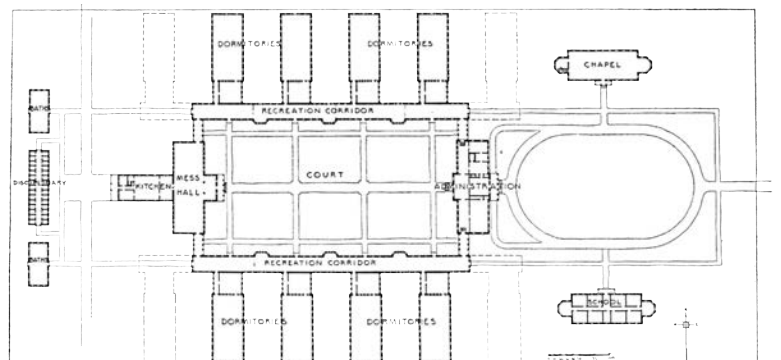


ORIGINAL PLAN FOR OCCOQUAN

Occoquan, VA
1916

The plan consists of two different dormitory spaces: one smaller space with 50 beds and one larger space with 104 beds. Each linear space is flanked by accommodating toilets and a communal recreation room on one side. The courtyard is accompanied by a simple facade.

Figure 4.14



VIRGINIA WOMEN'S MULTI-CUSTODY CORRECTIONAL FACILITY

Richmond, VA
HOK and Moseley McClintock Group

The site layout, designed for 1354 beds by HOK in collaboration with the Moseley McClintock Group, consists of small-scale cruciform cell blocks arranged around a central courtyard. The plan features cost-effective designs including double cells over dormitory cells and a central outdoor space surrounded by a ring of buildings providing an inner security perimeter and primary access to additional programs and decentralized activities.

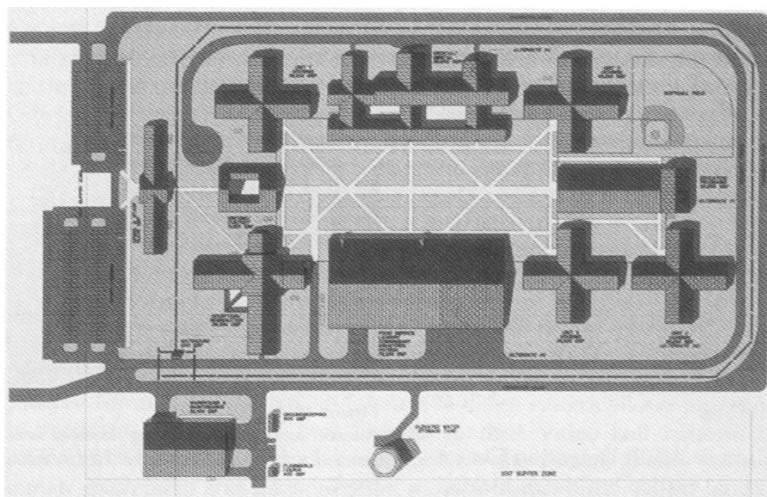
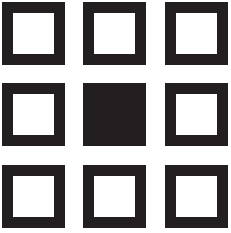


Figure 4.15

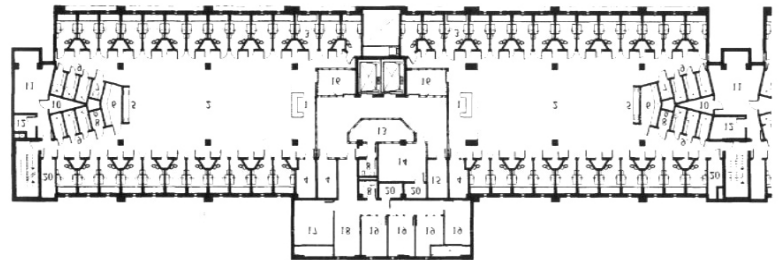


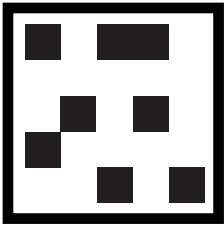
**BALTIMORE CENTRAL
BOOKING AND INTAKE
FACILITY IN BALTIMORE**

Urban Detention Facility
Baltimore, MD
1978 HOK Architects and SOJ
Architects

This facility was designed to implement efficiency by combining different kinds of holdings, including those awaiting trial, which is supported by the Criminal Justice system of the city that inhabits a portion of the building. This limits the transition for inmates awaiting trial. *Could this be problematic for the mentally ill, due to their failure to comply with other inmates?*

Figures 4.16 and 4.17





**FEDERAL CORRECTIONAL
INSTITUTION AT OTISVILLE**

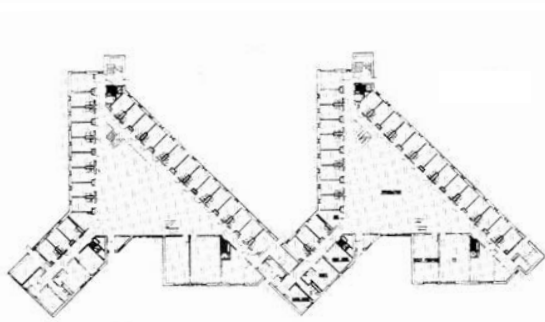
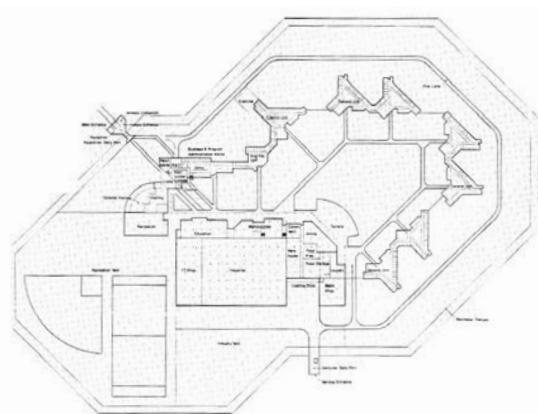
Otisville, NY

1981 Davis, Brody & Associates/
Large Moger Associates

The facility is 70 miles west of New York City, housing 500 males mostly from the northeastern United States. It's designed as a small town with activities centered around a "downtown concourse" that runs the length of the buildings, containing general inmate programs and services.

One main feature of this decentralized secure adult institution is that the building acts as its own security: the exterior envelope of the building acts as a perimeter in order to limit the surveillance to staff and devices inside. *Could this lessen the relationship between staff and inmates ultimately resulting in poorer care for the mentally ill?*

Figures 4.18 through 4.20



FIRST LEVEL



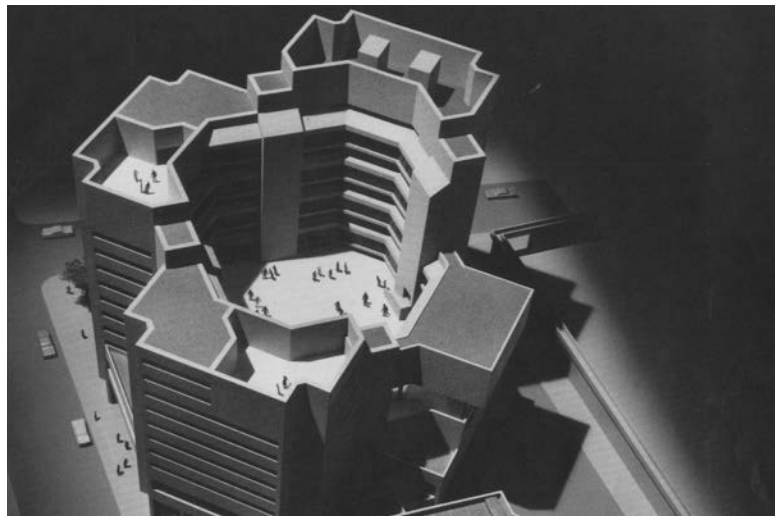
HYBRID URBAN + COURTYARD

MARYLAND RECEPTION DIAGNOSTIC AND CLASSIFICATION CENTER AT BALTIMORE

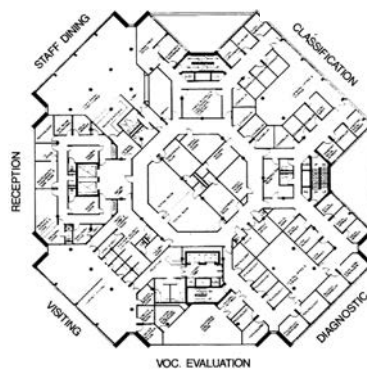
Baltimore, MD
1976 The Gruzen Partnership,
McLeod, Ferrara, Ensign

The purpose of this high-rise metropolitan correctional center is to house offenders after they have been sentenced. The building uses a softer approach to the exterior with a grey-brown facade. The central core allows for function in a self-contained manner, which lies adjacent to the multi-purpose areas located in one quadrant of the building. *Does this facility for mentally ill inmates offer enough space for activity and exposure to the outside environment? Is the contact with other people too distant by containment or too close by proximity?*

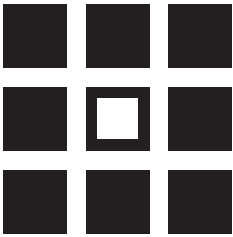
Figures 4.21 and 4.22



THIRD LEVEL



FIRST LEVEL



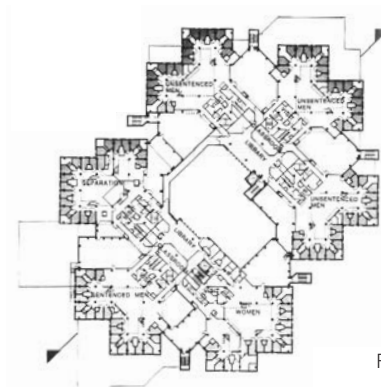
**CONTRA COSTA COUNTY
DETENTION FACILITY AT
MARTINEZ**

Martinez, CA
1978 Kaplan/McLaughlin

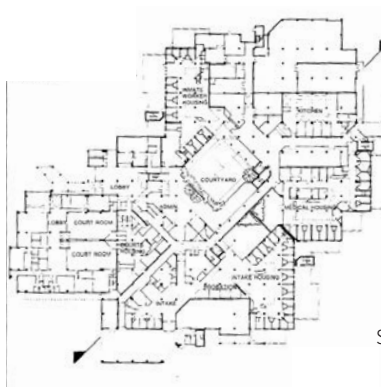
This urban detention facility is organized by a decentralized campus plan. The general housing units are divided into two multi-level, triangular modules, each containing 65 single rooms. The triangular modules are each arranged around a common area; every two modules are connected by staff offices and miscellaneous service areas. An additional module is used as a Special Housing Unit or administrative control/segregation unit.

There is a ten-bed medical clinic on the ground floor of the administration building for the provision of general health and dentistry. Patrol officers maintain the double-fenced perimeter of the grounds. As a result, staff do not have a large, congregational space away from the inmates. Any serious medical attention will result in an inmate being transferred to another type of facility.

Figures 4.23 and 4.24



FOURTH LEVEL



SECOND LEVEL

V.

"The [general] aims of imprisonment could be typified as punishment, deterrence, reform, and public protection."¹³ Accordingly, if the purpose of time in prison is to sentence punishment, inflict deterrence, promote reform, and protect the general public, then the objective of reform has failed. While some are able to make the most of their sentence, many prisoners return to prison shortly after their release. The New York State Department of Correctional Services reported that of their 63,698 inmates in custody on January 1, 2005, 35.1% had previously served a prison term.¹⁴ "Good prison practice that promotes good mental health makes the country safer because people in prison who have problems that are addressed are less likely to commit more crime after they leave."¹⁵ This begins by redefining the aims of imprisonment in order to relate to a large portion of the prison population: the mentally ill.

The objectives of healthcare in prison are conflicting: punishment versus rehabilitation; prisoner versus patient.¹⁶ "Prisons have to cope with mental illness of every severity, but, in addition, prisons accept the need to reduce further harm to mental well-being." Mental episodes, common among the mentally ill in prisons, align with

a disrespect for staff authority and result in punishment, including the lengthening of prison time. If there is any hope of relinquishing the ongoing care of the mentally ill in prison, it is vital that prisons prevent illness or the worsening of illness amongst prisoners on coming into prison.¹⁷

The ideological shift of viewing containment as a secondary social dynamic of incarceration as opposed to the primary dynamic will make way for the positive development and rehabilitation of prisoners by preparing for release.¹⁸ The Trecin Statement under the World Health Organization of Europe declares mental health promotion is possible in prisons and is an essential component towards rehabilitation.¹⁹ On the contrary of what Fred Cohen, professor emeritus of law and criminal justice at the State University of New York in Albany, might consider to be the creation of a solution within a problematic system, Melanie Jordan, student at the University of Nottingham School of sociology and Social Policy, claims that a union between mental health service provision and the criminal justice system could be considered the paramount to the success of both public services.²⁰

¹³ Melanie Jordan, "The prison setting as a place of enforces residence, its mental health effect, and the mental healthcare implications," *Health & Place* 17, (2011): 1061.

¹⁴ Kristine M. Gebbie et al. "Improving Access to Mental Health Services for New York State Prison Inmates," *Journal of Correctional Health Care* 14 2 (2008): 123.

¹⁵ Fraser, Gatherer, and Hayton, "Mental health in prisons: great difficulties but are there opportunities?" *Health & Place* 123 (2009): 413.

¹⁶ Melanie Jordan, "The prison setting as a place of enforces residence, its mental health effect, and the mental healthcare implications," *Health & Place* 17, (2011): 1065.

¹⁷ Fraser, Gatherer, and Hayton, "Mental health in prisons: great difficulties but are there opportunities?" *Health & Place* 123 (2009): 411-412.

¹⁸ Melanie Jordan, "The prison setting as a place of enforces residence, its mental health effect, and the mental healthcare implications," *Health & Place* 17, (2011): 1064.

¹⁹ Fraser, Gatherer, and Hayton, "Mental health in prisons: great difficulties but are there opportunities?" *Health & Place* 123 (2009): 411.

²⁰ Melanie Jordan, "Embracing the notion that context is crucial in prison mental health care," *British Journal of Forensic Practice* 12 4 (2010): 33.

The merging of 2 systems in the penal setting.

As the prison system begins to address mental health care, the objectives of the Department of Correctional Services and Mental Health Services in the United States start to overlap.



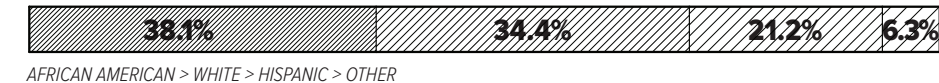
Figure 5.1

Characteristics of inmates in state prison facilities.

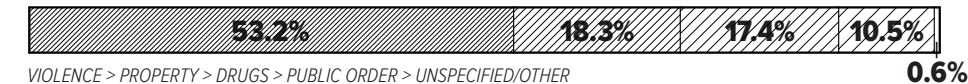
Gender ratio:



Race ratios:



Inmate-committed offenses ratios:



Inmate-education ratios (prior to conviction):

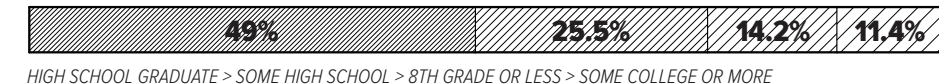


Figure 5.2

Prisons are, and have always been, a part of society, hence why prisoners retain all their legal rights excluding personal freedom.²¹ “The World Health Organization highlights their healthy prison concept to be a recognition that the health of prisoners is not the responsibility of the healthcare clinicians alone, but it is instead also dependent on the ethos and regime created in the penal setting.”²² Strategies for mental health care in prisons must include a range of facilities designed to cater to various inmate-needs in order to properly look after the mentally ill. The physical and social environments of prison should provide freedom from boredom and engagement in activity. “Despite the essential need for security, services provided in prison should be as seamless as possible with those outside.”²³ In order to maintain a connection with society and ease the transition that occurs at release from prison, it is important for an inmate to understand he is surrounded by freedoms, yet they are temporarily restricted until he has completed his rehabilitation sentence.



Figures 5.3 and 5.4

²¹ Fraser, Gatherer, and Hayton, “Mental health in prisons: great difficulties but are there opportunities?” *Health & Place* 123 (2009): 413.

²² Melanie Jordan, “The prison setting as a place of enforced residence, its mental health effect, and the mental healthcare implications,” *Health & Place* 17, (2011): 1062.

²³ Fraser, Gatherer, and Hayton, “Mental health in prisons: great difficulties but are there opportunities?” *Health & Place* 123 (2009): 411-413.



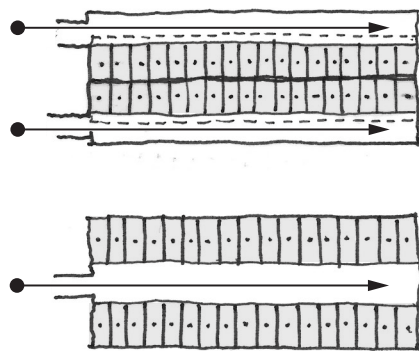
From left to right, Figures 5.5 through 5.10

“Problematic aspects of the prison environment are shared between its members, both [varying] staff and inmates. Many members of the prison staff spend more time in prison during their lives than the majority of prisoners.” This should pose an emphasis on the creation of prison spaces that not only benefit the inmates, but the staff as well. This includes proper supervision spaces for security and proper treatment spaces when medical staff can safely interact and form relationships with the inmates, who are considerably their patients. “It is very difficult to run prisons which are more or less escape proof, orderly and safe, which provide programmes aimed at changing offending behavior and offering prospects or rehabilitation, and which respect the human rights of staff and prisoners”.²⁴ While prison must remain escape proof, the aesthetic of traditional prison architecture reflects its intention to withstand many years and counteracts the reformative thinking that an inmate is only in prison temporarily.

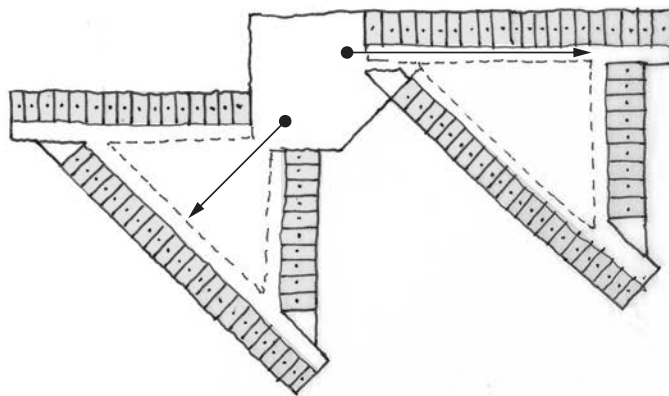
The daily life of a prisoner, and the daily work-routine of a member of the prison staff exploit the man’s basic right to freedom. “Mental health care professionals must practice in an environment concerned primarily with security, not care”.²⁵ While the care and treatment of prisoners is currently a matter of many factors, security is a matter of staffing defined by architecture. In order to balance the priority of rehabilitation to security, the architecture of prison must act as a host for proper treatment and reform.

²⁴ Melanie Jordan, “The prison setting as a place of enforces residence, its mental health effect, and the mental healthcare implications,” *Health & Place* 17, (2011): 1064-1065.

²⁵ Melanie Jordan, “Embracing the notion that context is crucial in prison mental health care,” *British Journal of Forensic Practice* 12 4 (2010): 32.

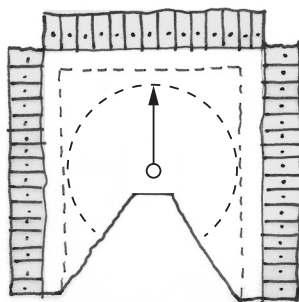


0 degrees

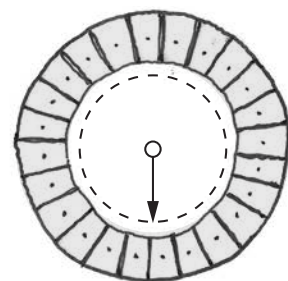


90 degrees

These diagrams illustrate the degree of surveillance created by the cellblock design. The rectangle and radial typologies, originally the model-designs for other prisons, provide the least amount of direct surveillance. While the panoptical typologies provides maximum surveillance, it does not provide the individual privacy that can only be found in a cell.



270 degrees



360 degrees

Figure 5.11

"The provision of healthcare is linked to the social and institutional nature of the place, [also known as] the prison milieu. Prison culture includes the prisoner-staff-surroundings relationship in tandem with the traditions, habits, rules, attitudes, customs, and codes that govern the social organization of the prison. Both prisoner and staff culture are now considered in turn, as the links between the social environment, the mental health of the prisoner population, and the provision of mental healthcare are crucial." In addition to providing treatment, relationships characterized by respect, fairness and sociability result in caring inmate-officer relationships, which increases prison officer job satisfaction. The importance of the staff in prison has been, and will continue to be, emphasized as major factor of the nature of prison culture. In order to provide inmates with stable social relationships, natural to human life, the compliance of staff is essential.

Unfortunately, the relationships between inmates in the general prison setting are harmful to the mentally ill. Upon entering prison, inmates

move from a free society with its social-class hierarchy into the prison setting with its absence of meaningful ascribed statuses. "The nature of mental health and place is evident clearly here, as those with overt mental health issues (as defined by the social group itself) are labelled negatively and placed at a cultural disadvantage in the social setting. Social classes [in prison] are argued to exist," but only to the knowledge of the inmates, meaning it is out of the control of prison staff.²⁶ "Health accounts are socially negotiated and setting-specific" amongst prisoners, so everyday notions of health and illness reflect identity and ideological values, meaning when an inmate is defined as different from, by, other prisoner he can begin to feel as he is told.²⁷ The obvious way to prevent the ostracizing of mentally ill patients within the custodial prison setting is to separately them from the general prison population.

²⁶ Melanie Jordan, "The prison setting as a place of enforces residence, its mental health effect, and the mental healthcare implications," *Health & Place* 17, (2011): 1062-1064.

²⁷ Melanie Jordan, "Embracing the notion that context is crucial in prison mental health care," *British Journal of Forensic Practice* 12 4 (2010): 33.

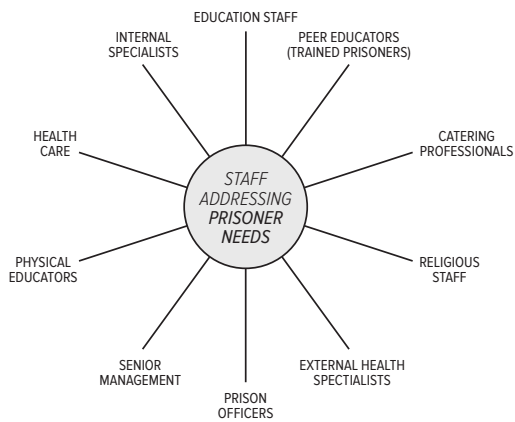


Figure 5.12: The variety of activities and obligations dictated by the daily routine require many different trained staff professionals.

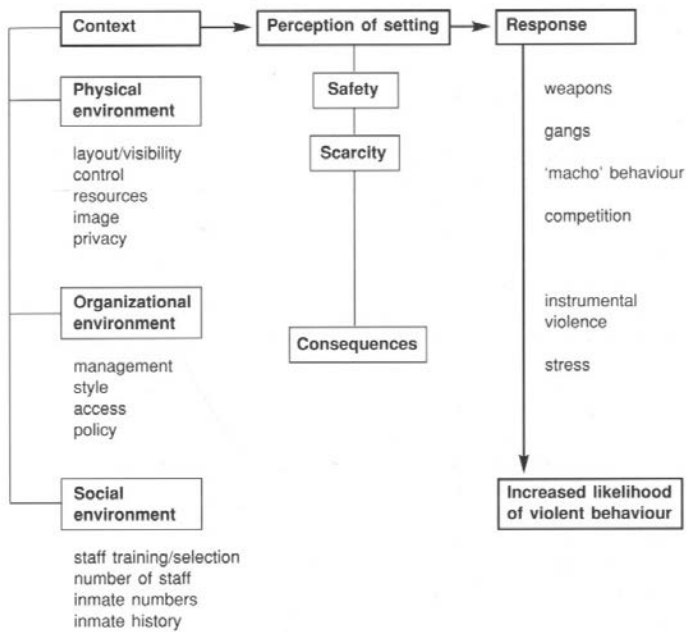


Figure 5.13 Model showing the violent results of prison architecture.

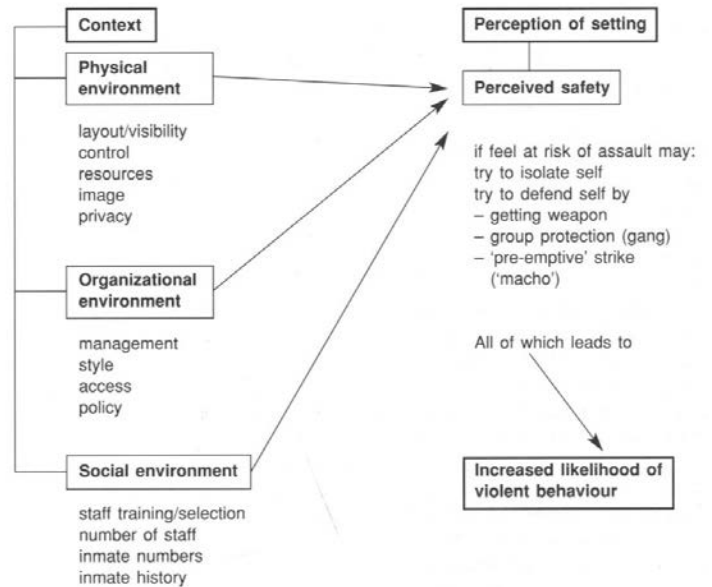
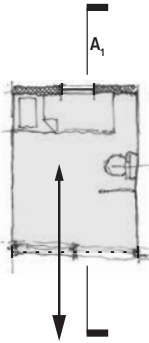


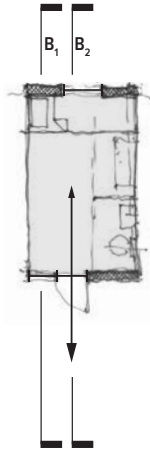
Figure 5.14: Model showing how the perception of the prison setting could lead inmates to feel in danger and at risk of harm.

CELL TYPES / OCCUPANCY

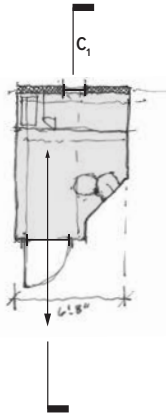
SINGLE OCCUPANCY CELL
(MINIMUM SECURITY)



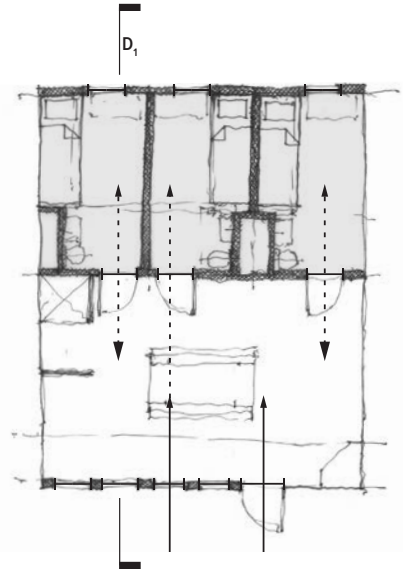
SINGLE OCCUPANCY CELL
(MINIMUM SECURITY)



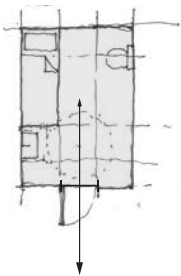
SINGLE OCCUPANCY CELL
(MAXIMUM SECURITY)



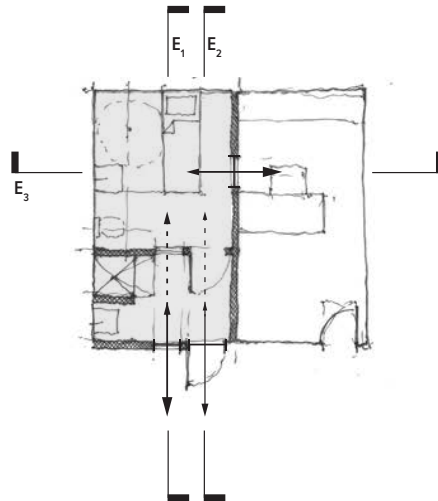
SINGLE OCCUPANCY CELLS + COMMON
DAY ROOM
(MINIMUM SECURITY)



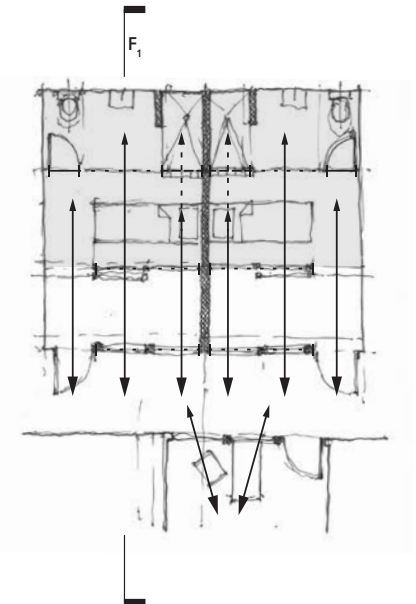
A.D.A. COMPLIANT SINGLE
OCCUPANCY CELL
(MINIMUM SECURITY)



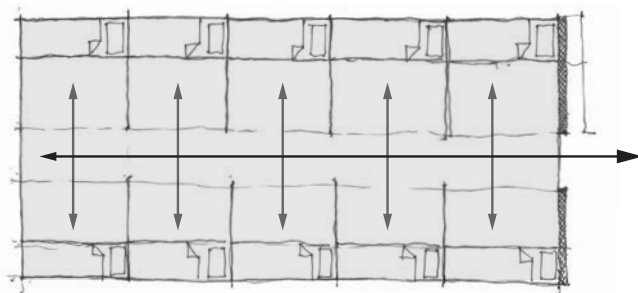
A.D.A. COMPLIANT MEDICAL
ISOLATION CELL
(MAXIMUM SECURITY)



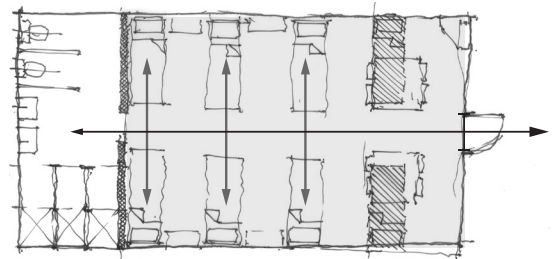
SINGLE OCCUPANCY MEDICAL CELL
(MAXIMUM SECURITY)



MULTIPLE OCCUPANCY CELL
(MINIMUM SECURITY)



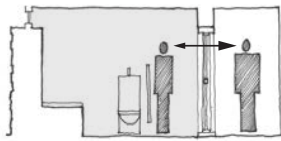
DORMITORY-STYLE MULTIPLE OCCUPANCY CELL
(MINIMUM SECURITY)



The prison cell is a place of interaction extremes. In the traditional prison typologies, the cell was a space of isolation; the inmates would practice a daily routine in silence from sunrise to sundown. If the design allowed for it, inmates could communicate between cells. Never could inmates converse without knowing other inmates could listen. On the contrary, the isolation cell did not allow clear sound to escape, meaning the inmate could not be heard, therefore communicate, with anyone nearby. The prison cell should be understood as a space for sleeping and self-reflection, a private space apart from others; it should prevent the spread of disruptive noises. However, the cell should not be made a space of punishment; a space of isolation. In order to not feel isolated while being alone, an interaction with elements should be present.

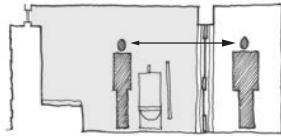
SECTION A₁

Direct physical contact between inmate cell and staff

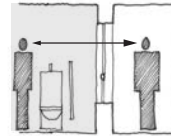


SECTION B₁

Direct visual contact between inmate cell and staff from two viewpoints

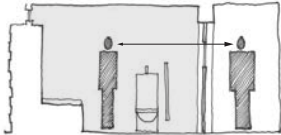


SECTION B₂



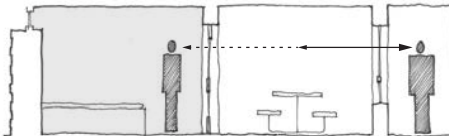
SECTION C₁

Direct visual contact between inmate cell and staff



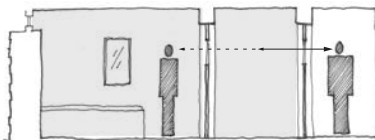
SECTION D₁

Direct visual contact between inmate cell and staff, separated by interim space

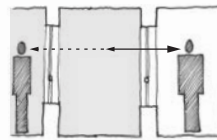


SECTION E₂

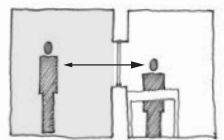
Direct visual contact between inmate cell and staff from multiple viewpoints, two separated by interim space



SECTION E₂

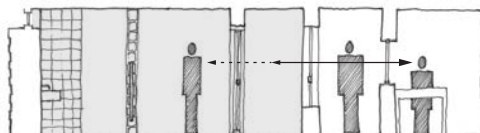


SECTION E₃



SECTION F₁

Direct visual contact between inmate cell and staff from multiple viewpoints, separated by interim space



It could be argued that prison is beneficial for some individuals, “[since] incarceration is the first time that routine care, including mental health care, [has been] received.”²⁸ However, confinement is known to cause hardships in prison for those dealing with mental illness, along with many other prison occurrences and tendencies. The World Health Organization lists factors contributing to poor mental health among prisoners as overcrowding, various forms of violence, enforced solitude, lack of privacy, lack of meaningful activity, isolation from social networks, insecurity about the future, and inadequate health services, mental health especially.²⁹ “Prisoners desire ‘something to do’ and ‘someone to talk to’ in the belief that it would help alleviate experienced mental distress.”³⁰ With the help of proficient staffing, providing proper spaces for inmates to take part in meaningful activity can only be achieved through rethinking the types of spaces that currently exist in prisons.

Supervision of mental health care and administration is potentially the greatest challenge to the development of mental health services in Western countries.³¹ Prison culture refers to the formal and informal social organization of the institution, [as in] codes, rules, attitudes, options, habits, behavior systems, traditions, customs [implemented by members of the staff,] and the interactions between prisoners, prison staff and the structural surroundings.³² It would be easy to assume that little interaction would yield few problems,

but in the instance of mental illness, solitude is problematic. “Prison mental health services need to reflect appropriately the exceedingly convoluted nature of inmates’ experiences of incarceration and consider whether the nature of health provision is compatible with the prison social environment.”³³ Because each inmate possesses varying degrees of one or multiple disorders, the social organization of prisons should embrace its complexity by providing difference spaces that allow for different types of interactions. While complying with staff, inmates should have the freedom to spend their time in whatever environment suits their needs, which could promote mental stability.

Right, Figure 5.15: This series of modified diagrams from MAB Architettura e Urbanismo illustrates the moves taken to rethink the building of Detention Centre as an alternative to the typical detention facility.

²⁸ Kristine M. Gebbie et al. “Improving Access to Mental Health Services for New York State Prison Inmates,” *Journal of Correctional Health Care* 14 2 (2008): 123.

²⁹ Fraser, Gatherer, and Hayton, “Mental health in prisons: great difficulties but are there opportunities?” *Health & Place* 123 (2009): 412.

³⁰ Melanie Jordan, “Embracing the notion that context is crucial in prison mental health care,” *British Journal of Forensic Practice* 12 4 (2010): 33.

³¹ Fraser, Gatherer, and Hayton, “Mental health in prisons: great difficulties but are there opportunities?” *Health & Place* 123 (2009): 412.

³² Melanie Jordan, “Embracing the notion that context is crucial in prison mental health care,” *British Journal of Forensic Practice* 12 4 (2010): 31.

³³ Melanie Jordan, “The prison setting as a place of enforces residence, its mental health effect, and the mental healthcare implications,” *Health & Place* 17, (2011): 1064.

OBJECTIVES

Relationship to
the community

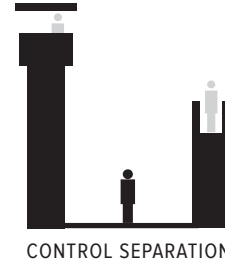
Evolved



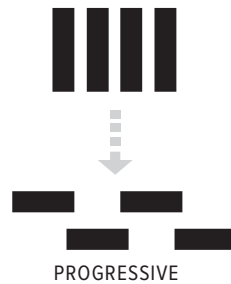
Typical



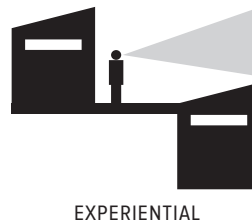
Dialogue of
surveillance



Progressions of
treatment and
space



Environmental
exposure



Built v. unbuilt
inter-activity



Form of privacy



“Social compliance is, in part, a result of the [prison] milieu.”³⁴ The idea of therapeutic communities as agents of applying order to the lives of the mentally ill through architecture and inmate classification dates back to the 1850-asylums in the United States. “Therapeutic communities are places where the social relationships and structure of the day are designed to aid health and wellbeing. Treatment environments are influenced by an array of factors including the institutional framework, the physical set-up of the care center, organizational factors, and suprapersonal factors”³⁵.

Therapeutic environments can be thought of as the interplay of four main factors, each which has varying degrees of influence: the patients; the staff; the context of care; external constraints and influence. Components of a therapeutic environment are noted to include apt personal space and privacy, access to diversional activities and shared philosophy of care; if carefully constructed, this environment could form a more therapeutic social milieu in prisons. Her Majesty’s Prison Grendon, the first psychiatric prison in the United Kingdom, opened in 1962 with the

objective of using total organization as a part of the therapeutic regime in order to produce an environment that encouraged the inmate to express his feelings and create relationships with members of the staff. A 1995 study of the prison resulted in 94% of the men admitting to benefitting from the therapeutic regime, supporting the prison’s techniques of promoting group-based decision-making and communal spaces and rejecting rules and regulations as denoted in conventional prison culture.³⁶ The physical environment of group activity would be defined by the number of inmates in a group and the number of groups in the prison. “[Although] there is no research that directly assesses the effects of the prison environment upon mental health, [and] significantly more research is needed into what works for whom in the prison context,” an effort to further research various group spaces or programs could be used as a precedent for creating similar possible spaces for inmates.³⁷ This could prove similar to group therapy spaces in prisons, which must consider a level of security.

³⁴ Melanie Jordan, “Embracing the notion that context is crucial in prison mental health care,” *British Journal of Forensic Practice* 12 4 (2010): 31.

³⁵ Melanie Jordan, “The prison setting as a place of enforces residence, its mental health effect, and the mental healthcare implications,” *Health & Place* 17, (2011): 1064.

³⁶ Melanie Jordan, “The prison setting as a place of enforces residence, its mental health effect, and the mental healthcare implications,” *Health & Place* 17, (2011): 1065.

³⁷ Melanie Jordan, “Embracing the notion that context is crucial in prison mental health care,” *British Journal of Forensic Practice* 12 4 (2010): 33.

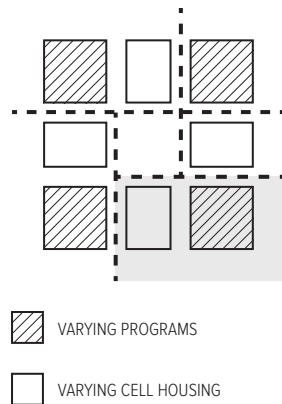


Figure 5.16: The varying programs divide the different cell types segregating inmates by sentence and level of threat to general community population. This method could be used for dividing inmates into smaller clusters for treatment.

The implementation of diversion-based approaches to policy and practice, which intend to divert mentally ill inmates from the prison custodial environment, is inconsistent and therefore imposes reform on neither types of inmates.³⁸ Fortunately, there have been notions of creating a consistent method of inmate classification that would attempt to address mental illness at the point of arrival in prison. While segregating mentally ill inmates would not alter the social hierarchy deemed by prisoners in the general penal setting, it could provide a space without the degrading status and the mental and physical disturbances that come along with it.

In 2003, a study conducted by the New York State Department of Correctional Services, Department of Health, and Office of Mental Health in partnership with the Columbia University School of Nursing Center for Health Policy revealed a lack of integration of medical and mental health services, that screening for mental health needs was not conducted using a standardized instrument, and that staff would welcome a screening tool. The aim of this group study was to increase the likelihood of appropriate screenings being made in hope of

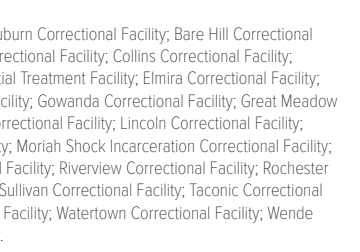
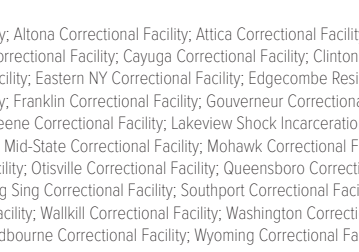
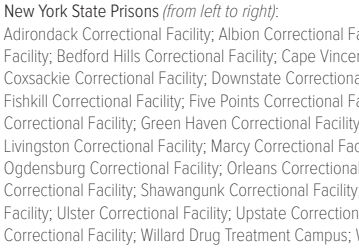
diagnosing and treating inmates with mental illness, in reaction to the large amount of those incarcerated suffering from mental illness, especially those misdiagnosed and lacking adequate treatment and care. This resulted in the creation of the New York State Brief Screening Tool, which was created as a by-product of the Patient and Health Questionnaire and the Referral Decision Scale with the intentions to maintain validity and reliability in the prison setting, identify cases of mental illness (bipolar disorder, schizophrenia, major depression, and panic disorder), be administered and scored easily, and be used by the health professional not specializing in mental health. The screening tool was implemented in a study consisting of 92 maximum security inmates and had a positive predictive value of 0.84 ultimately diagnosing 14% of the inmates screened as possessing a mental illness.³⁹

In order to progress with the attempt to determine the types of spaces that better facilitate the treatment of mental illnesses, a simple device identifying inmates as possessing different mental disorders is necessary.

³⁸ Melanie Jordan, "Embracing the notion that context is crucial in prison mental health care," *British Journal of Forensic Practice* 12 4 (2010): 30.

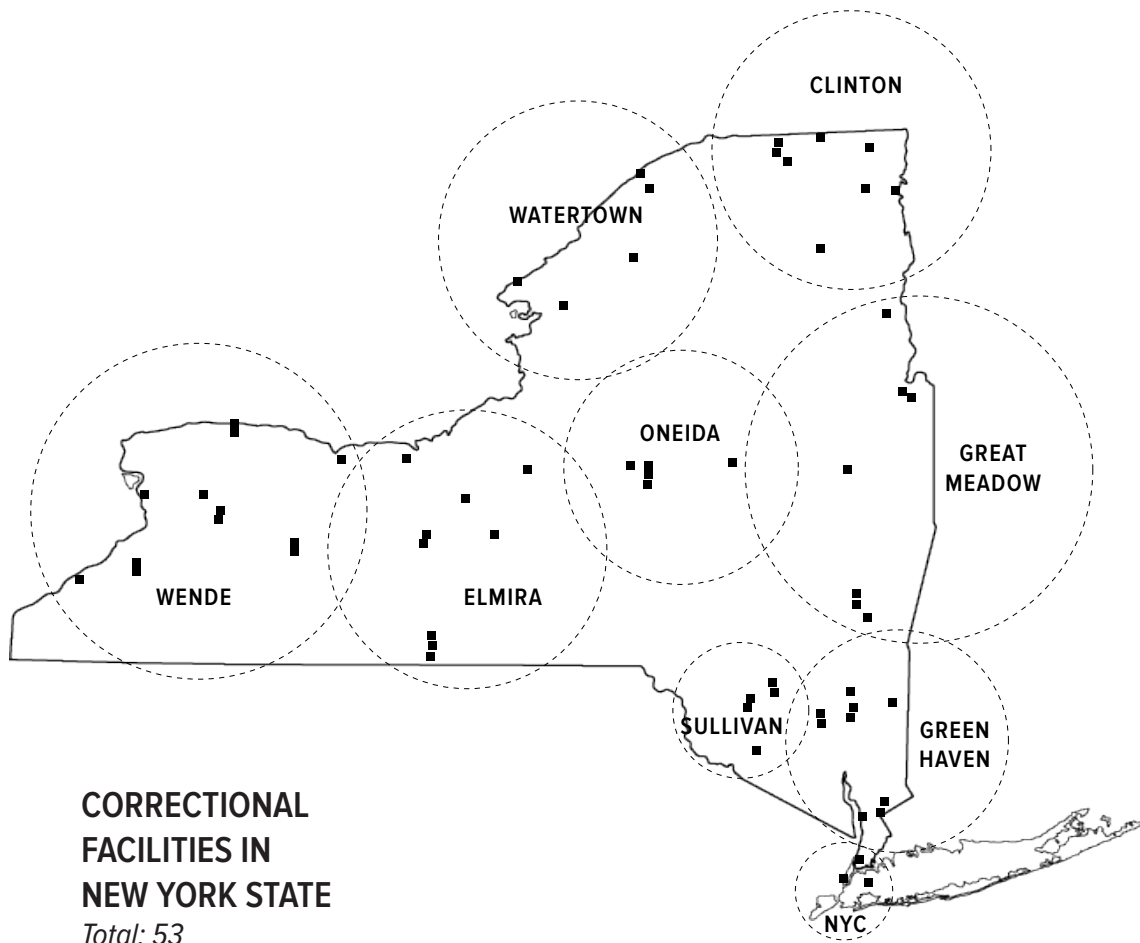
³⁹ Kristine M. Gebbie et al. "Improving Access to Mental Health Services for New York State Prison Inmates," *Journal of Correctional Health Care* 14 2 (2008): 124.





New York State Prisons (from left to right):

Adirondack Correctional Facility; Albion Correctional Facility; Altona Correctional Facility; Attica Correctional Facility; Auburn Correctional Facility; Bare Hill Correctional Facility; Bedford Hills Correctional Facility; Cape Vincent Correctional Facility; Cayuga Correctional Facility; Clinton Correctional Facility; Collins Correctional Facility; Cocksackie Correctional Facility; Downstate Correctional Facility; Eastern NY Correctional Facility; Edgecombe Residential Treatment Facility; Elmira Correctional Facility; Fishkill Correctional Facility; Five Points Correctional Facility; Franklin Correctional Facility; Gouverneur Correctional Facility; Gowanda Correctional Facility; Great Meadow Correctional Facility; Green Haven Correctional Facility; Greene Correctional Facility; Lakeview Shock Incarceration Correctional Facility; Lincoln Correctional Facility; Livingston Correctional Facility; Marcy Correctional Facility; Mid-State Correctional Facility; Mohawk Correctional Facility; Moriah Shock Incarceration Correctional Facility; Ogdensburg Correctional Facility; Orleans Correctional Facility; Otisville Correctional Facility; Queensboro Correctional Facility; Riverview Correctional Facility; Rochester Correctional Facility; Shawangunk Correctional Facility; Sing Sing Correctional Facility; Southport Correctional Facility; Sullivan Correctional Facility; Taconic Correctional Facility; Ulster Correctional Facility; Upstate Correctional Facility; Walkkill Correctional Facility; Washington Correctional Facility; Watertown Correctional Facility; Wende Correctional Facility; Willard Drug Treatment Campus; Woodbourne Correctional Facility; Wyoming Correctional Facility.



New York is home to 53 state correctional facilities including 4 federal prisons; there are 111 federal prisons in the United States.⁴⁰ The Auburn Correctional Facility in Central New York was the original 'rectangle' prison typology that immediately influenced the design of the Sing Sing correctional facility and many others during the late nineteenth century and early twentieth century. Over time, more and more facilities have been built, widening the scope of prison typologies across the state.

Figure 5.17

⁴¹ "Facility Listing," New York State Department of Corrections and Community Supervision, accessed November 30, 2014, <http://www.doccs.ny.gov/facilist.html>.

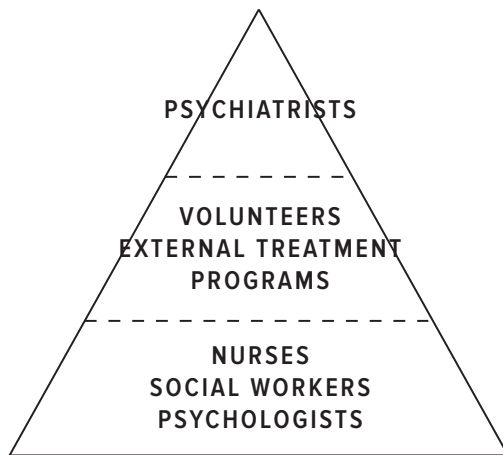


Figure 5.18

"We intentionally built a bottom-heavy, early-detection, early-prevention model, thinking it was cheaper and more effective. The most effective people in that scheme, of course, are the doctors. You need the doctors, but they rarely provide the direct care. They do medication management. You want people at the base who are interacting and throwing a ball around with these people, talking to them about their medication, talking to them about their families, helping them out."

Fred Cohen

Fred Cohen's partaking in the *Dunn v. Voinovich* lawsuit led to an investigation which exposed the inadequate care conditions for the mentally ill in the Ohio State Prison system. The findings included a lack in the provision of access to care, physical resources, and the human resources. In order to make improvements, there was a restructuring of staff personnel and the addition of classification considerations when placing mentally ill inmates amongst the general prison population. He stressed the importance of everyday interactions between inmates and the 'base' staff: nurses, social workers and psychologists. Despite the dramatic improvements seen in Ohio, Cohen claims "[prison] will never be the [ideal] place where you want to provide treatment, and it will never reach sort of idealistic goals".⁴¹

What Cohen could not improve were the spaces where all these interactions take place. His guidelines for staff structure and inmate-staff interaction could be combined with the inmate classification-techniques being tested in New York State Department of Correctional Services, Department of Health, and Office of Mental Health and lead to a more care-oriented design. Ideally, New York State could create the first 'treatment' typology for the penal setting.

⁴¹ Fred Cohen, *Frontline*, December 2, 2004.

With every generalization comes many exceptions; not all prisoners will fit a mold. Prison culture is not simple, nor homogenous, and it is important not to underestimate the complexity of the social settings as they pertain to the context and nature of a prison.⁴² Fred Cohen looks at three particular areas of a prison to determine if the facility has the potential to administer proper care: do inmates have relatively easy access to needed care; are the physical resources in place that are required -- bed space, different kinds of transitional treatment space, hospital space; and do you have the human resources -- the doctors, the nurses, the psychologists -- in place. While psychological staff consisting of nurses, social workers and psychologists are necessary on a day-to-day basis, in order to communicate and structure recreation in conjunction with inmates, the doctors remain the most important health care providers. The

most important aspect of treatment is to detect the mental illness before it worsens. For those inmates who do not appear to progress with their treatment and pose a danger to themselves and prison staff, there are momentary mental health units providing intensive care in order to reduce the inmates' chances of extending their sentence through disruptive behavior. Eventually, the idea is that these inmates will return to their original prison facility and continue to receive medical treatment there.⁴³ With the level of treatment found in the mental health units, the standards of care proposed by Cohen, and the New York State Brief Screening Tool, inmates are more likely to be properly diagnosed and classified within the prison mental health system.

⁴² Fraser, Gatherer, and Hayton, "Mental health in prisons: great difficulties but are there opportunities?" *Health & Place* 123 (2009): 413.

⁴³ Fred Cohen, *Frontline*, December 2, 2004.

Reflection upon the prison environment as a place of enforced residence, as opposed to a place of custody or confinement, should be encouraged.⁴⁴ If prison is understood as a community, it may be easier to accept the idea that not every mentally ill inmate will cope with one type of reformatory prison living or cell typology, in the same way that not all humans thrive in the same type of living environment.

The principle of equivalence between prison mental health services and community-based mental health care is unsuitable conceptually for prison, as similar environments do not exist in the community model of mental health care.⁴⁵ Considerably, the only precedents of mental care architecture are asylums, aging persons care facilities and hospitals, and therefore, prison facilities with respect to mental health will be modeled after the idea of a therapeutic environment and built with the intention of reflecting community and individual spaces common to society. In the attempt to address multiple mental illnesses, the idea of creating multiple, yet slightly different environments could be modeled.

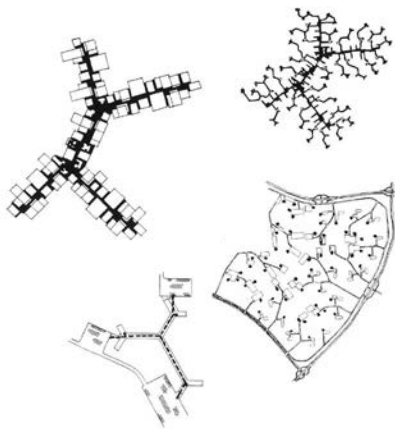
⁴⁴ Melanie Jordan, "The prison setting as a place of enforced residence, its mental health effect, and the mental healthcare implications," *Health & Place* 17, (2011): 1065.

⁴⁵ Melanie Jordan, "Embracing the notion that context is crucial in prison mental health care," *British Journal of Forensic Practice* 12 4 (2010): 29.

VI.

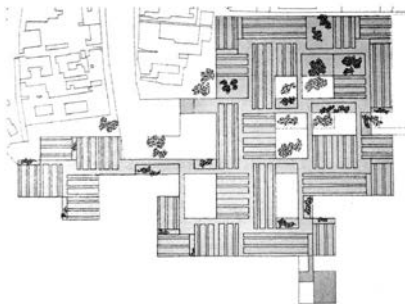
SOCIAL TYPOLOGIES AND PRECEDENTS

Each of the projects stated below aim to create a new type of interaction between the spaces and the users.



MAT BUILDING TYPOLOGIES

THESE INCLUDE: STEM, OPEN LINEAR ORGANIZATION, STEM + OPEN LINEAR ORGANIZATION, STEM + WEB, CENTRE AND PATTERN OF OPEN SPACES AND PROGRAM



VENICE HOSPITAL PROJECT

LE CORBUSIER
HOSPITAL
VENICE, ITALY
1966



BERLIN FREE UNIVERSITY

CANDILIS-JOSIC-WOODS
ACADEMIA
BERLIN, GERMANY
1973

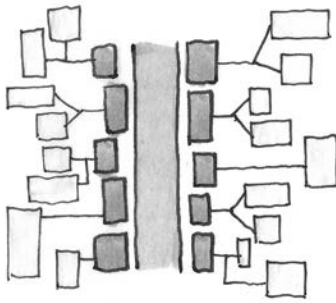


LA CERTOSA DEL GALLUZZO A FIRENZE

NICCOLÒ ACCIAIOLI
MONASTERY
GALLUZZO, FLORENCE, ITALY
1365

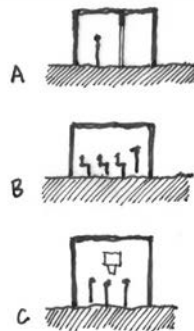
MAT BUILDING TYPOLOGY

When function comes to enrich the fabric and the individual gains new freedoms of action through a new shuffled order based on interconnection, close-knit patterns of association and possibilities of growth, diminution and change.



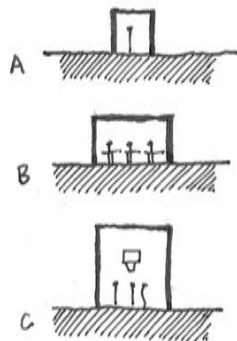
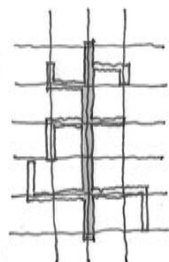
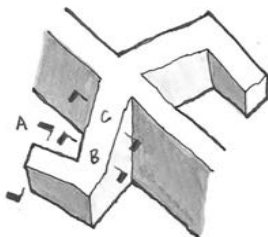
STEM CONCEPT

A central stem with surrounding functions, branches of secondary functions or private spaces.



OPEN LINEAR ORGANIZATION

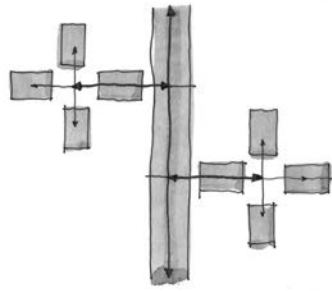
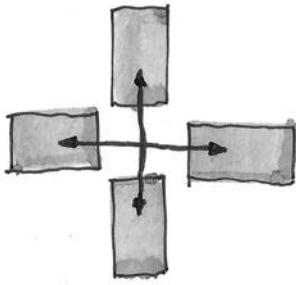
The circulation is linear and takes the human through a sequence of spaces.



STEM + OPEN LINEAR ORGANIZATION

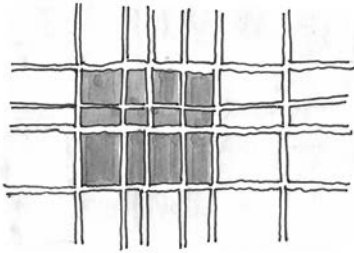
Open linear organizations all lead back to a greater stem of commercial space.

Figures 6.5 through 6.10



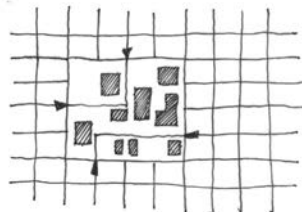
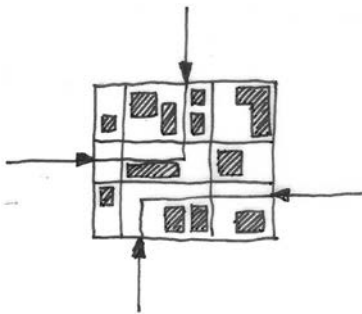
STEM + WEB

An alternative to zoning based on human mobility in space, moving away from grouping in social classes; typically a web with a center of activity, but come together while maintaining separate functions or basic needs.



CENTRE

Formed by the concentration of streets over the concentration of buildings.

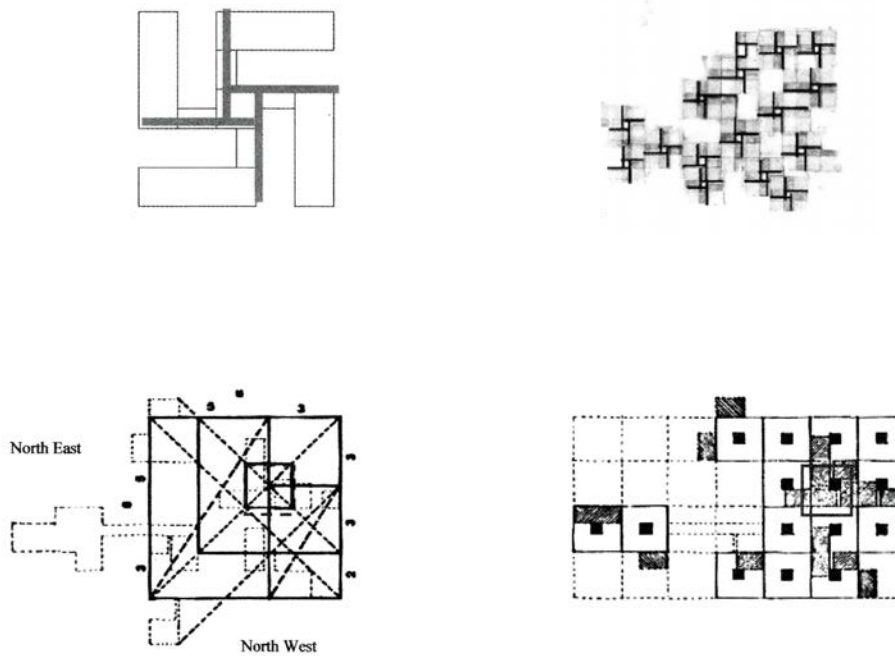


PATTERN OF OPEN SPACES AND PROGRAMS

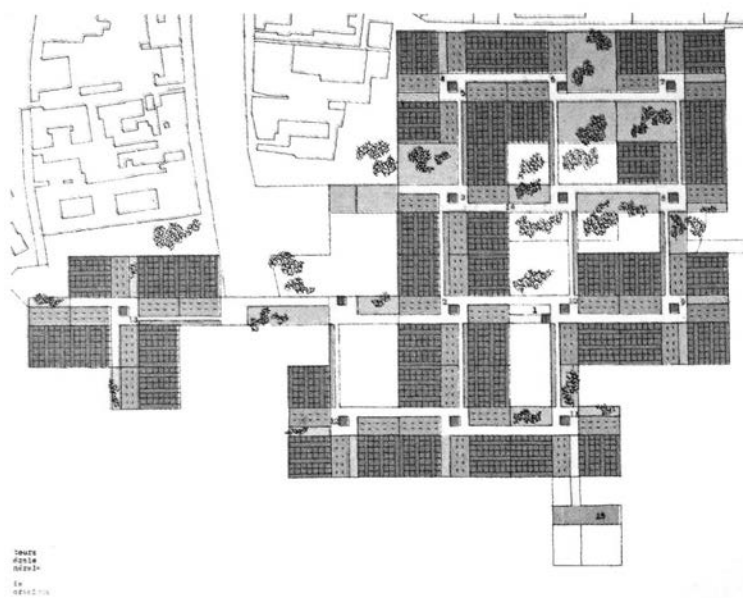
The intention of recreating urban fabric which fails to connect with its surroundings; it creates its own urban fabric.

VENICE HOSPITAL PROJECT

Aims to foster the interaction of different functional and user groups (inmates, security staff, health staff, administrative staff, visitors) along with multiple paths and routes that bring together various areas (individual spaces, group spaces, large activity spaces). The Venice Hospital plan is designed to interact with the city through architectural amalgamation.

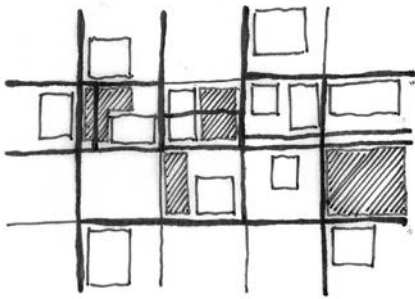


Figures 6.11 through 6.14



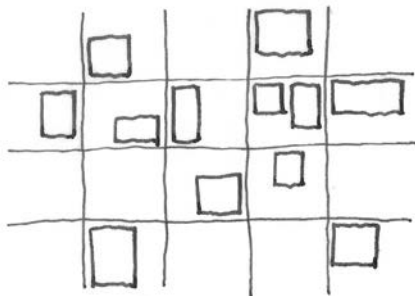
LEGENDA
SINTESI
DELLA
PROGETTAZIONE

VENICE HOSPITAL PROJECT



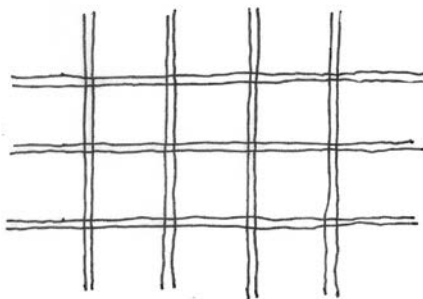
LEVEL 3

the circulation adapts to the needs of the building



LEVEL 2

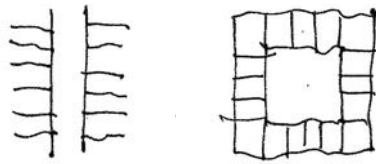
the architecture inhabits the voids in the circulation



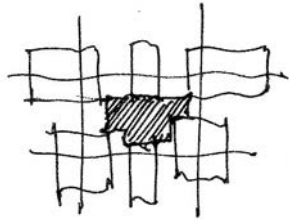
LEVEL 1

the circulation

Figures 6.16 through 6.22



*the fundamental
spaces: corridors and
courtyards*



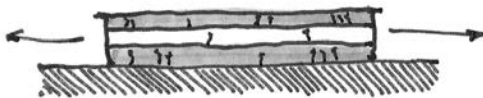
*the core: the exchange of
ideas and the formation of
relationships*



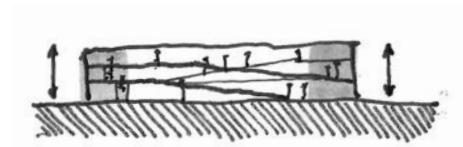
Level 3
THE URBAN SPACIAL CONFIGURATION OF THE
SURROUNDING CITY

Level 2
THE URBAN AND ARCHITECTURAL INTEGRATION

Level 1
THE URBAN REGENERATION OF THE SITE



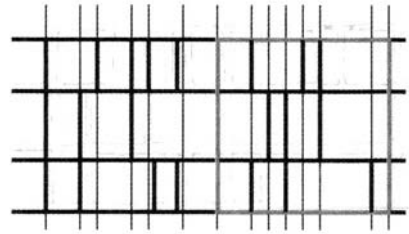
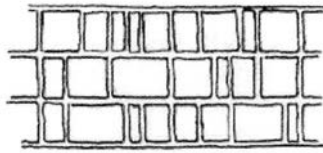
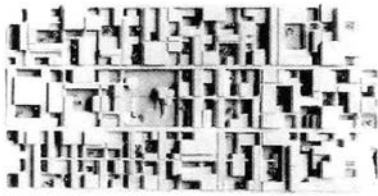
horizontal circulation = human to context interaction



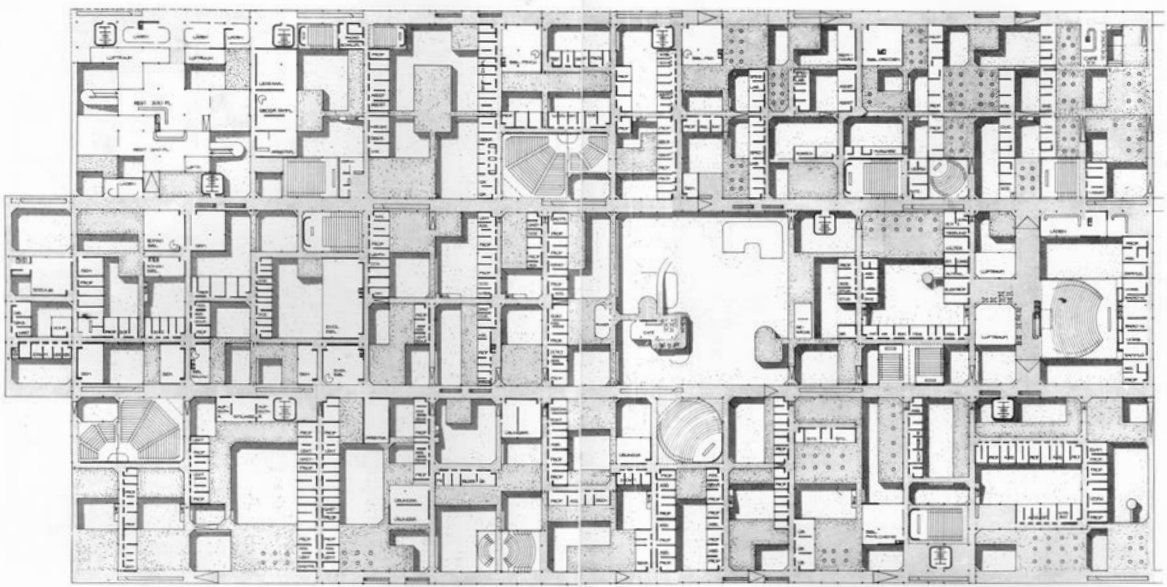
vertical circulation = human to human interaction

BERLIN FREE UNIVERSITY

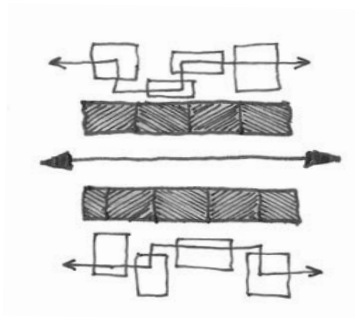
A horizontal weave of programmatic and circulatory elements creating a field space dependent on its internal mechanisms. The objective of privacy without the use of physical barriers that become psychological barriers, set out to correct alienation and promote social interaction (on an internal level). The rejection of functional zoning and the implementation of human mobility in space.



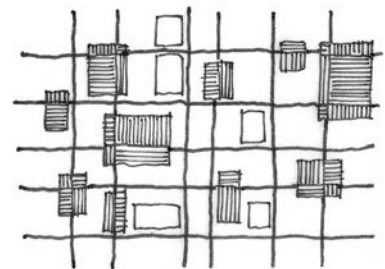
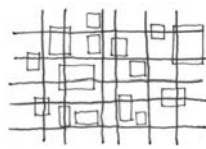
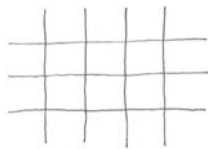
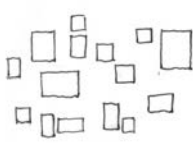
Figures 6.23 through 6.26



BERLIN FREE UNIVERSITY

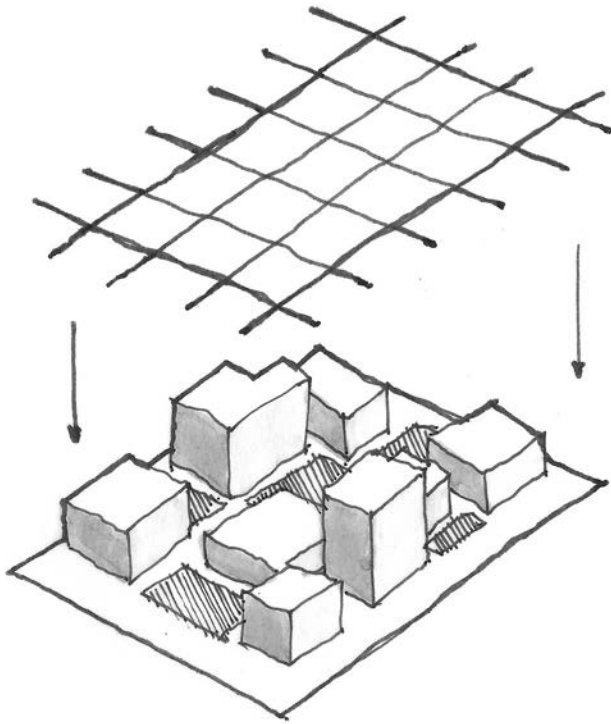


The main spaces are located in the main stem for easy accessibility; circulation remains open and non-centric. The secondary circulation is made up of multiple places of privacy and tranquility.

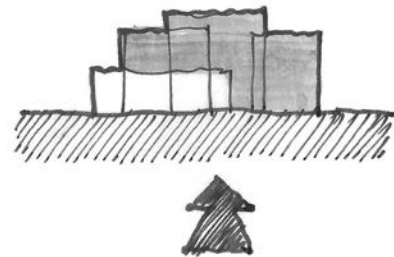
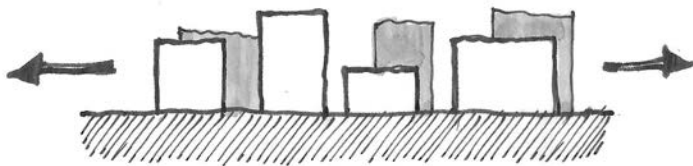


The circulation is intercepted by the building. The circulation then becomes a condition of open space versus closed space. The variety of circulation reveals different interactions.

Figures 6.27 and 6.30



A grid placed over an existing fabric creating a multi-level matrix resulting in an overlay of interactions and services with traditional spaces, expected form due to the grid, as well as unexpected spaces such as entrances and promenades.



By layering a grid, the new interactions are only horizontal, compared to the Venice Hospital Project where human interactions are vertical and contextual interactions are horizontal.

LA CERTOSA DEL GALLUZZO A FIRENZE

A centralized courtyard becomes decentralized by the corridor, due to its ability to dictate arrangements of all other programs.

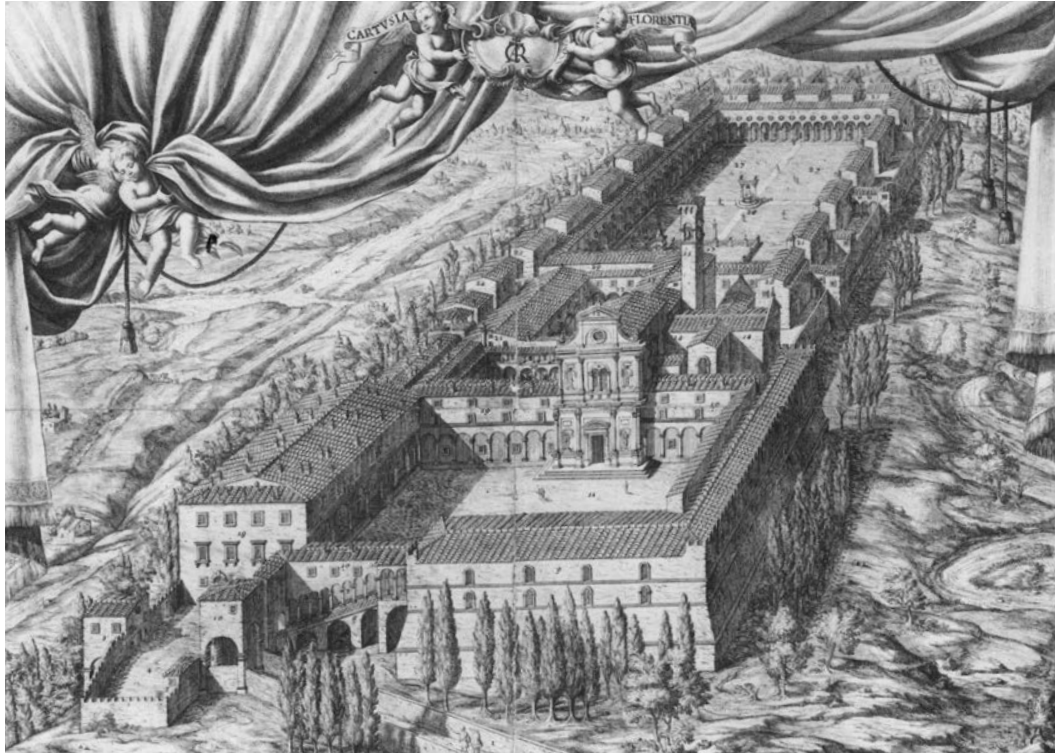
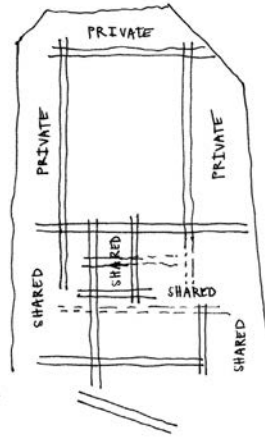
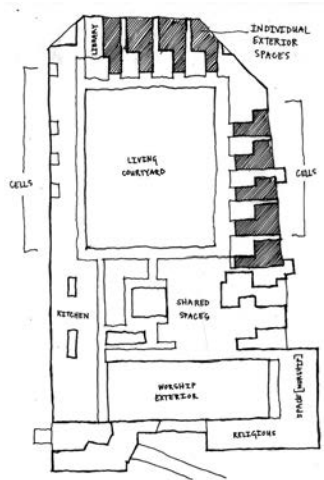
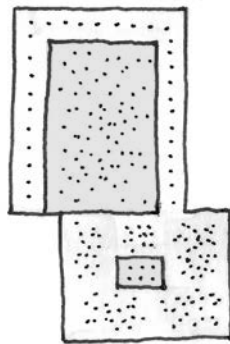
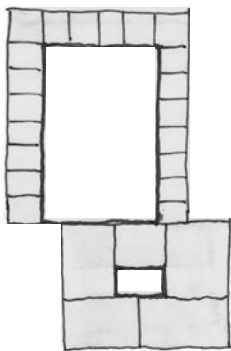


Figure 6.31

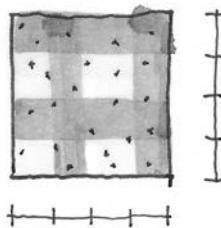


DECENTRALIZED PLAN

The corridors dictate the circulation and redirect the activity from the central courtyard based on the concentration of small, interior private spaces around large, exterior shared spaces and the many interior shared spaces containing the many small, exterior shared spaces



There is a juxtaposition of the relationship between interior versus exterior space and private versus public space; the large courtyard is surrounded by many small private spaces while the small courtyard is surrounded by larger communal spaces. This creates a polycentric plan of activity in the plan.



Figures 6.32 and 6.33

VII.

TREATMENT PROGRAM

The objective of the treatment program is to instill a sense of obligation and care within the inmates, in addition to promoting group activity. Due to the many tasks that are part of agricultural work, the inmates obtain agricultural skills through daily instruction and proceed to tend to vegetation on site grounds. The program will follow the community supported agriculture model, which is designed for the management of a variety of crops, each denoting a privately-owned share. The CSA suggests 1 full-time seasonal worker for a total of 20 shares, and up to 30 shares per acre. With 24 inmates to 1 acre, there will be 6 shares, or crops, which will be tended to by 4 different inmates throughout one day. The crops need to be harvested, washed, cooled, divided into equal shares, and packed into bags or boxes, which requires many hands and solid management skills.⁴⁶ The produce will then be used to feed the inmates or others at local soup kitchens. Some of the inmates could be familiar with the places and people they are feeding, if they had come from a life of poverty and relied on free-meal centers in

the past; they can relate to the people they are feeding, people similar to themselves.

A similar initiative has begun at the Southern Ohio Correctional Facility. In this scenario, inmates and others from a nearby correctional facility are transported to SOCF to work the 1 1/2 acres of land during the week. The inmates spend their time cultivating the land and planting to grow crops such as sweet potatoes, red potatoes, radishes, green beans, cauliflower, bell peppers, watermelon, carrots, onions, zucchini, lettuce, beets, and corn. These crops are harvested and donated to the local homeless shelter and food pantries.⁴⁷ This unique program speaks to the objective of reform by centering a daily routine around basic human needs and activities.

This will require exterior land for growing produce, exterior land for skills training, interior space for skills training, and interior space for growing during off-seasons. The inmates will continue to work in their small groups of 12 to allow much attention to be paid to each inmate.

⁴⁶ "Managing a CSA farm production, labor and land (Research Brief #40)," Center for Integrated Agricultural Systems, accessed November 29, 2014, <http://www.cias.wisc.edu/managing-a-csa-farm-1production-labor-and-land/>.

⁴⁷ "Southern Ohio Correctional Facility," Ohio Department of Rehabilitation and Correction, accessed November 30, 2014, <http://www.drc.ohio.gov/Public/socf.htm>.

INMATE ORGANIZATION STRUCTURE
& DAILY ROUTINE

A typical prison structure usually consists of large groupings of inmates, by means of security and efficiency. This type of organization allows for little privacy and restricts effective social work.





Research indicates that social reform activities should consist of groups no larger than 15 inmates, with only a few social workers or specialists.⁴⁸ Maintaining this ratio and increasing the number of inmates is not ideal, as inmates are less likely to be given the opportunity to participate in overcrowded activities. Smaller, more intimate spaces allow for closer relationships between inmates and staff and inmates themselves.

In this study, the inmates will be organized in groups of 24, which will allow for different numbers of clusters consisting of 4, 6, 12, and 24 inmates. The various activities of the daily routine will determine when and how the inmates should be clustered. This change creates a fluctuation of interactions designed to mimic a daily routine outside prison.

An inmate will be given opportunities for self-reflection and group-reflection within each day to cope with life in prison and ultimately provide an environment of reform.

⁴⁸ Nadaya Brantley, by Emily Lodato, November 17, 2014.

INMATE SPACES

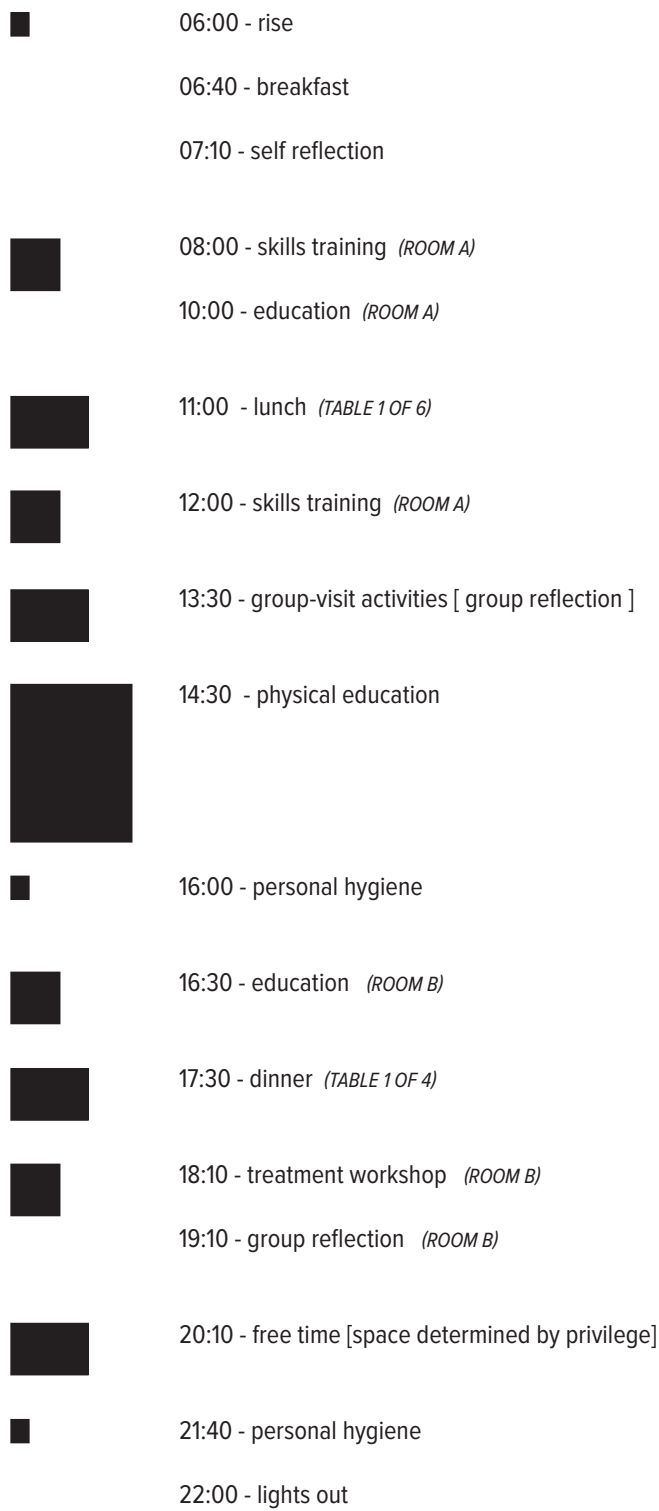
	INDIVIDUAL SPACE [1 INMATE] 75 SQ. FT.
	SMALL GROUP SPACE [12 INMATES] 375 SQ. FT.
	LARGE GROUP SPACE [24 INMATES] 600 SQ. FT.
	RECREATIONAL SPACE [24 INMATES] 3,100 SQ. FT.



TREATMENT SPACE
43,560 SQ. FT. = 1 *ACRE* [24 INMATES]

PROPOSED INMATE DAILY ROUTINE

This is an example of a daily routine for one inmate at the beginning of his sentence. He is assigned to a variety of individual and shared spaces throughout the course of one day, as follows:



00:00 01:00

INMATE DAILY ROUTINE SPACE SEQUENCE
THE AMOUNT OF TIME EACH INMATE WILL SPEND IN EACH SPACE
SIZE DURING ONE DAY [TEN MINUTE INCREMENTS].

02:00 03:00

04:00 05:00

06:00 07:00

08:00 09:00

10:00 11:00

12:00 13:00

14:00 15:00













16:00 17:00

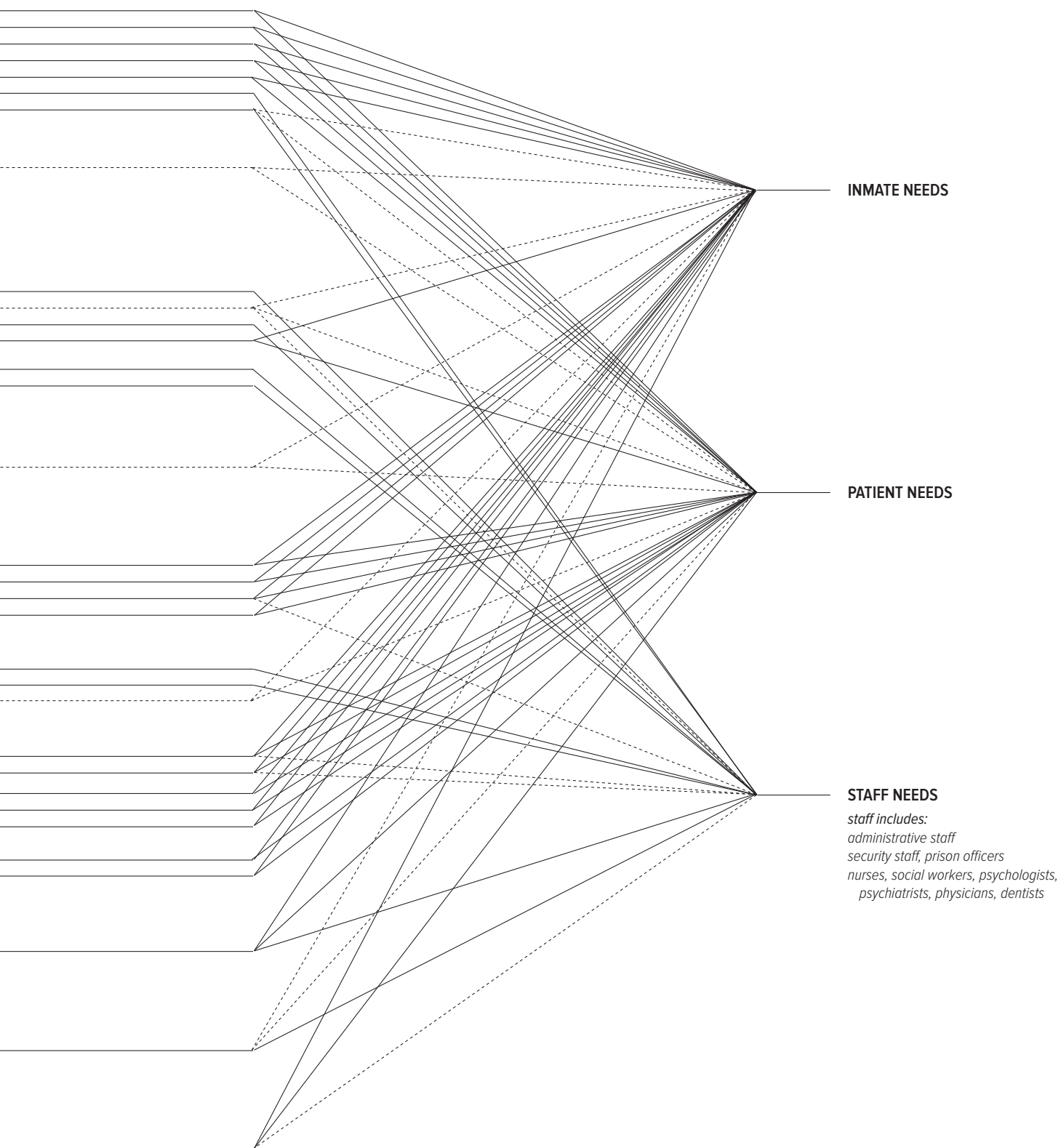
18:00 19:00

20:00 21:00

22:00 23:00

PROGRAM / FUNCTION / NEED

SPACE	SIZE	# OF SPACES	OCCUPANCY PER SPACE	OCCUPANCY	FUNCTION[S]	
	75 SQ. FT.	24	1	INMATE ADMINISTRATIVE STAFF SURVEILLANCE STAFF	BREAKFAST	<hr/>
		4	1		SELF-REFLECTION	<hr/>
		6	2		PERSONAL HYGIENE SLEEPING FREE TIME	<hr/> <hr/> <hr/>
					ADMINISTRATIVE OFFICE SPACE SURVEILLANCE OFFICE SPACE	<hr/> <hr/>
	80 SQ. FT.	1	N/A		BOOK STORAGE FREE TIME	<hr/> <hr/>
	200 SQ. FT.	2	N/A 6	VISITORS : INMATES	ENTRANCE	<hr/>
					LOBBY	<hr/>
					SECURITY CHECKPOINT	<hr/>
					VISITOR & INMATE M'TING SPACE	<hr/>
	250 SQ. FT.	1	24	STAFF	LOCKER STORAGE PERSONAL HYGIENE	<hr/> <hr/>
	300 SQ. FT.	1	24	INMATES	LAUNDRY FACILITIES	<hr/>
	375 SQ. FT.	2	12 12	INMATES INMATES	SKILLS TRAINING EDUCATION	<hr/> <hr/>
					TREATMENT WORKSHOP	<hr/>
					GROUP REFLECTION	<hr/>
					FREE TIME	<hr/>
	500 SQ. FT.	2	24 N/A	INMATES	MEETING SPACE CONFERENCE SPACE	<hr/> <hr/>
					STORAGE	<hr/>
	550 SQ. FT.	1	3	INMATES	HEALTH ADMINISTRATION MEDICAL TREATMENT	<hr/> <hr/>
					LUNCH DINNER	<hr/> <hr/>
					GROUP VISIT ACTIVITIES	<hr/>
	600 SQ. FT.	2	24 2	INMATES STAFF	FREE TIME RELIGIOUS SERVICE FOOD SERVICES	<hr/> <hr/> <hr/>
	3,100 SQ. FT.	1	24	INMATES	RECREATION GROUP VISIT ACTIVITIES	<hr/>
	10,000 SQ. FT.	1	40	VEHICLES	PARKING	<hr/>
	43,560 SQ. FT.	1	24	INMATES	TREATMENT SPACE [INTERACTION WITH THE ENVIRONMENT, DEVELOPMENT OF COMPASSION]	<hr/>



In order to foster human interactions, the spaces must meet the needs of the all who spend their time at the prison. Once the spaces are designed according to function they can be assigned to a specific user or users.

VIII.

LOCATION REQUIREMENTS FOR FUTURE PRISONS

With the objective of reform over custody.

To be within reasonable proximity to the community in which prisoners have their closest ties to—

To be near county or state justice centers for proximity to lawyers and probation officers—

To be in proximity to a town or community where staff would come from—

To be near local community activities and volunteer centers to attract programs to help inmates learn values from real-life experience—

To be within reasonable proximity to medical treatment for severe medical emergency care—

A part of the rehabilitation process consists of an inmate developing positive relationships with his peers, but his former relationships outside of prison are important for him to maintain as preparation in the aid of his release. Long Island provides the necessities for the treatment program, relatively open space and land, and is easy to access via public transportation. It's proximity to the water is an amenity, exposing the inmate to nature.

The amount of time it would take to travel from Manhattan to Kings Park is approximately 1 hour by car and 1.5 hours by train, the Long Island Rail Road. The railroad also conveniences visitors from throughout the tri-state area and upstate New York.

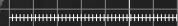
Kings Park is approximately 45 minutes from both John F. Kennedy International Airport and LaGuardia Airport, and within 10 miles of Long Island MacArthur Airport.

There are approximately 17 motels/hotels within an 8-mile radius of the Kings Park State Hospital site for visitors to stay at.

LEGEND



100 ACRES



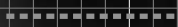
LIRR Long Island Rail Road



I-495 Long Island Expressway



NY 908G Northern State Parkway



NY 907M Grand Central Parkway



NY 908K Sunken Meadow State Parkway



NY 908K Sagtikos State Parkway



NY 908J Robert Moses Causeway

LONG ISLAND SOUND

KINGS PARK
SUFFOLK COUNTY, NY
Kings Park Psychiatric Center

SMITHTOWN BAY

Kings Park Train Station
LIRR Port Jefferson Line

Shepherd's INN

8 MI.
RADIUS

5 MI.

2 MI.

Suffolk County
Police Dept.

County Criminal Justice
Coordinating Council

The Patchogue
Neighbors INN

Long Island
MacArthur Airport

WINDY HILLS
NASSAU COUNTY
SUFFOLK COUNTY

GREAT SOUTH BAY

NORTH ATLANTIC OCEAN





SMITHTOWN BAY

Sunken Meadow
State Park

St. Johnland
Nursing Home

SUNKEN
MEADOW CREEK

Kings Park
Psychiatric Center

1 ACRE = 43,560 SQ. FT.



SITE

Location: *Kings Park, Suffolk County, New York (former site of Kings Park State Hospital)*

Penal Facilities are a part of society. By re-inhabiting the site of a formerly existing mental hospital that still partially operates, located in a community familiar with outdated mental health treatments, the design for reform has the opportunity to learn or influence current treatments facilitated by architecture.

KINGS PARK STATE HOSPITAL

The Kings Park Psychiatric Medical Center opened in 1885; shortly after it became known as the Kings Park State Hospital. Its 600 acres is located on the North Shore of Long Island just looking over Sunken Meadow State Park onto the Long Island Sound. The plan for the center included over 90 buildings, which were built during the late 1800's and early 1900's. The designs were dictated by functions and implemented a colonial and Georgian Revival. The master plan included its own laundry facilities and power plants, playing fields, swimming pools and other facilities.⁴⁹

The Kings Park Psychiatric Medical Center was originally built as a rural branch of the Kings County Asylum in Brooklyn.⁵⁰ The hospital was one of the earlier developments that impacted the community of Kings Park; it provided employment and was a consideration in the construction of the Long Island Rail Road station in Kings Park.

In 1993, just before the hospital's closing, the community reported complaints and concerns regarding patients wandering around the town unsupervised. The plan for the hospital never intended to be fenced in, and as a result of treatment patients were allowed to leave for short periods of time. While this issue was resolved when the hospital closed three years later, this type of program want to be contained to limit the worries of civilians living nearby.

The hospital shut down in 1996 due to new drug therapies and a new understanding of the rights of the mentally ill.⁵¹ Today, the Office of Mental Health continues to operate two group homes and one residential care center for adults on the existing grounds.

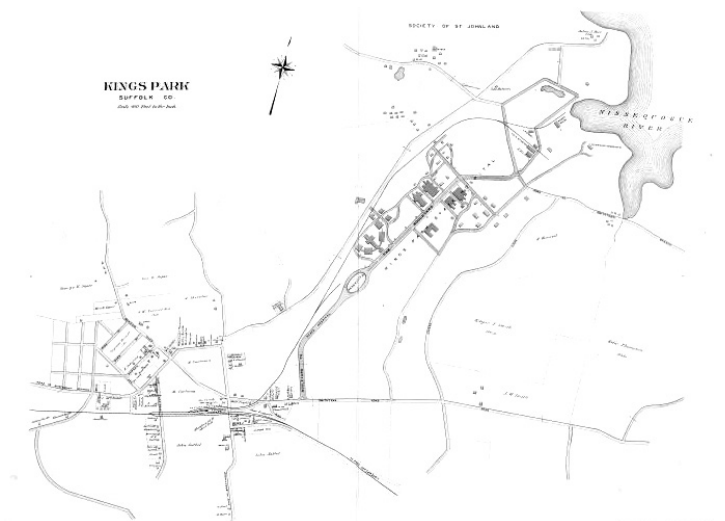


Figure 8.1

⁴⁹ Vivien Kellerman, "Kings Park and State Hospital to Ease Strained Ties," *The New York Times*, November 7, 1993, accessed December 2, 2014.

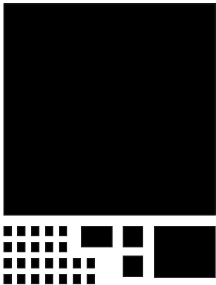
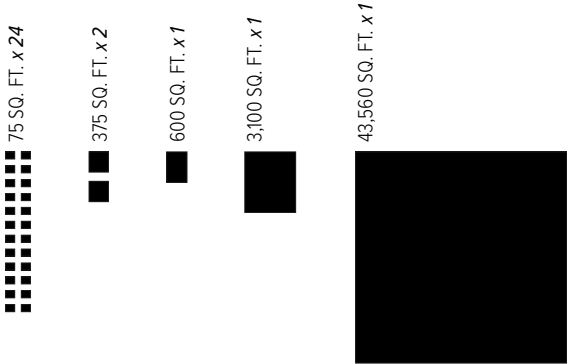
⁵⁰ Valerie Cotsalas, "Presto! This Land is Parkland," *The New York Times*, January 14, 2007, accessed December 2, 2014.

⁵¹ Lawrence Downes, "Erasing the Past at the Ghost Hospital," *The New York Times*, August 4, 2012, accessed December 2, 2014.

SITE + PROGRAM

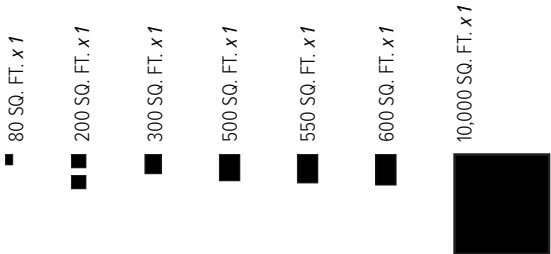
INMATE PROGRAMS

- Individual Space
- Small Group Space
- Large Group Space
- Recreational Space
- Treatment Space



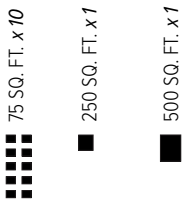
SERVICE PROGRAMS

- Library
- Lobby
- Visitors Space
- Laundry Facilities
- Storage
- Health Facilities
- Kitchen
- Parking



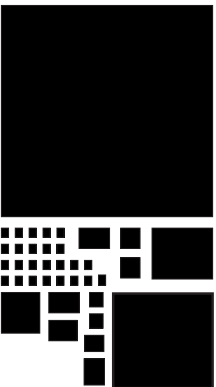
STAFF PROGRAMS

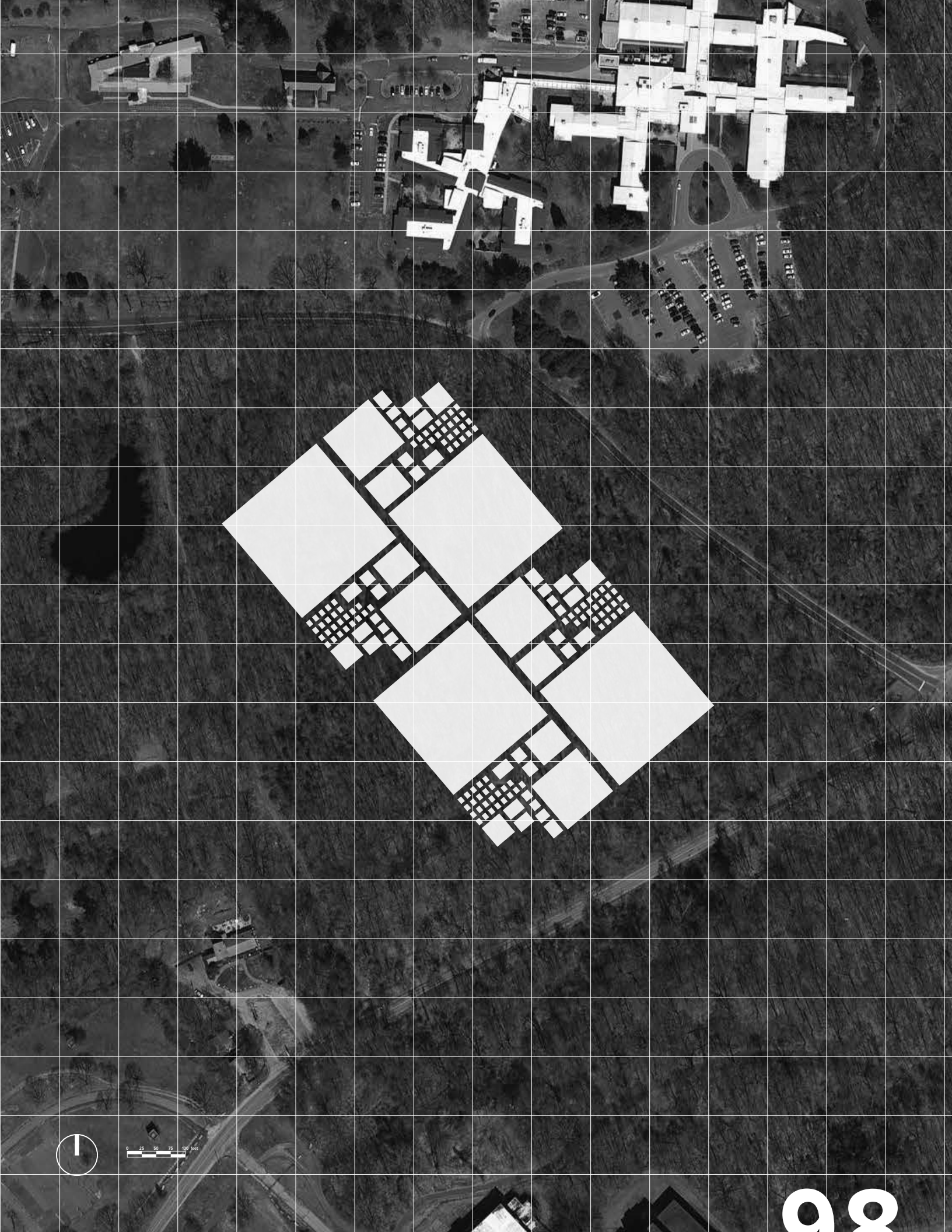
- Administration/Surveillance
- Lockers/Facilities
- Meeting Space



The total area of the listed programs per 24 inmates is 1.46 acres. This includes space for 24 permanent staff members, 3 visitors at one time, and approximately 40 parked vehicles.

This size can comfortably be accommodated 4 times on this site, resulting in a total acreage of 5.84, or 254,960 square feet. This would mean that the total inmate population is 96, with equal permanent staff.



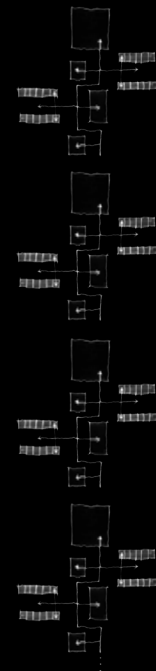
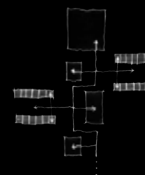


STEM CONCEPT



The primary stem is made up of communal spaces and the secondary stems consist of individual cells. The variability of secondary stems allows for individuals to experience different types of communal and living spaces, whether they be an intimate void between communal buildings or large-scale activity spaces that allow many inmates to interact at one time. The scheme remains decentralized and open to allow easy access to secondary stems.

While this scheme appears similar to the telephone pole penal scheme, the role of the primary stem and the secondary stems are reversed; the primary stem is no longer used as simply a connector of greater functional spaces, but becomes a series of spaces with many functions. Similarly, the main circulation will run along the primary stem, but would include a high activity of inmate circulation in addition to staff circulation.

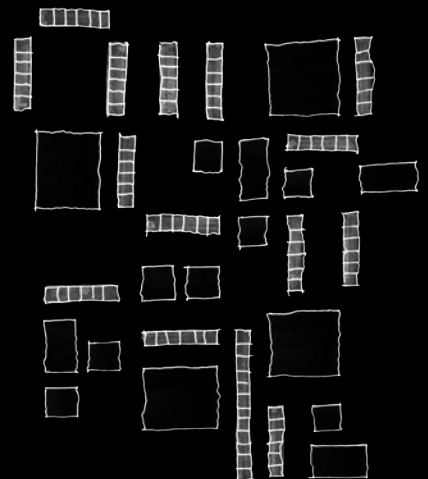
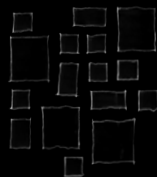
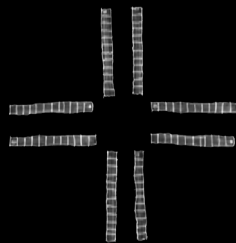


PATTERN OF OPEN SPACES AND PROGRAMS



By layering a cruciform prison plan of individual cells with a decentralized plan of communal activity spaces, a variety of encounters between programs is created. While the decentralized plan appears stronger in the collaboration, the concept of the corridor has adapted to develop an overlapping of circulations. Therefore, the plan is without hierarchy and no longer emphasizes a grouping of inmates by any standard.

The multitude of spaces poses a challenge for a future layer of security, but by imposing a more structured inmate circulation through a daily routine the staff will be able to better track inmate activity similar to in a typical campus plan.

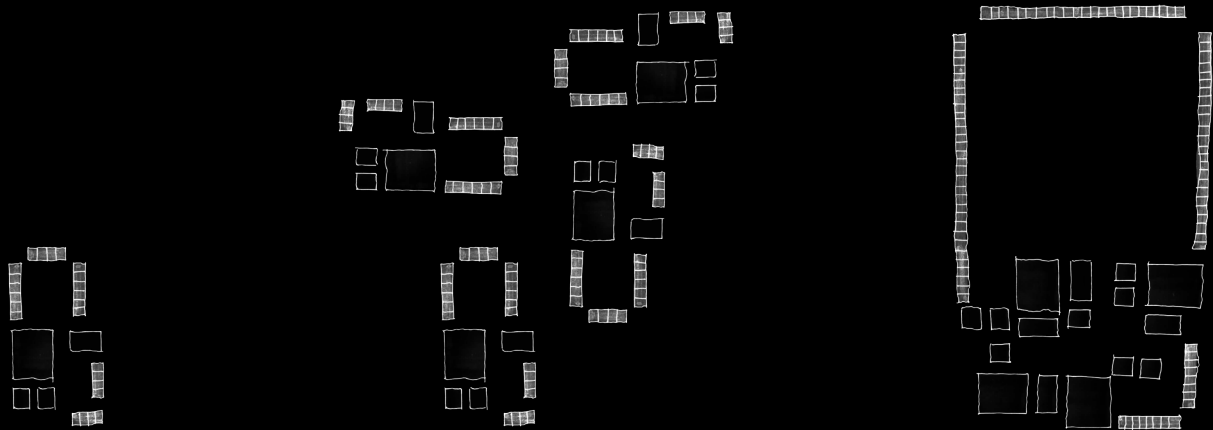


DECENTRALIZED PLAN

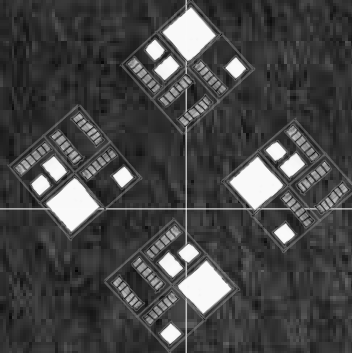
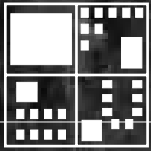


The basis for the decentralized plan comes from the organization of a monastery: a large courtyard surrounded by the majority of monk living quarters and a collective of communal spaces with a small courtyard surrounded by few living spaces. The individual spaces open onto the large courtyard, but also include views to exterior surroundings and a private exterior space. The idea of providing private spaces for self-reflection in addition to communal, interactive spaces meets the privacy needs of inmates; they allow an inmate to make his own decisions and learn from the positive and negative influences surrounding him, as he will encounter these in life after prison.

The plan, for one living courtyard especially, emphasizes a lifestyle of freedom and open space as opposed to a complex circulation of interactions and encounters. There is a greater separation between individual and communal spaces.

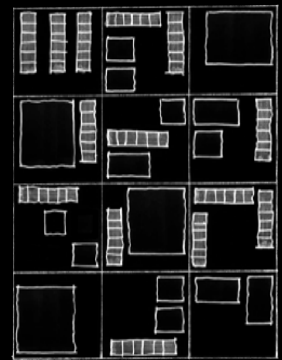
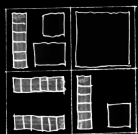
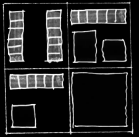
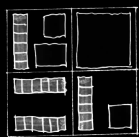


CENTRE ORGANIZATION



The interactions between streets, the human circulation, denotes the placement of buildings. By rejecting a hierarchy of streets, the plan becomes polycentric creating multiple central spaces within the grid of circulation determined by the placement of programs. Implementing a hierarchy creates areas of high activity with human traffic, which could result in different types of central spaces: central spaces of movement versus central spaces of idleness, which would be located in areas with fewer paths of circulation.

The decision to reject or implement hierarchy will result in very different types of human interactions, but ultimately provide a variety of spaces. Integrating the individual spaces and communal spaces poses few opportunities for resulting intimate spaces within communal activity zones.

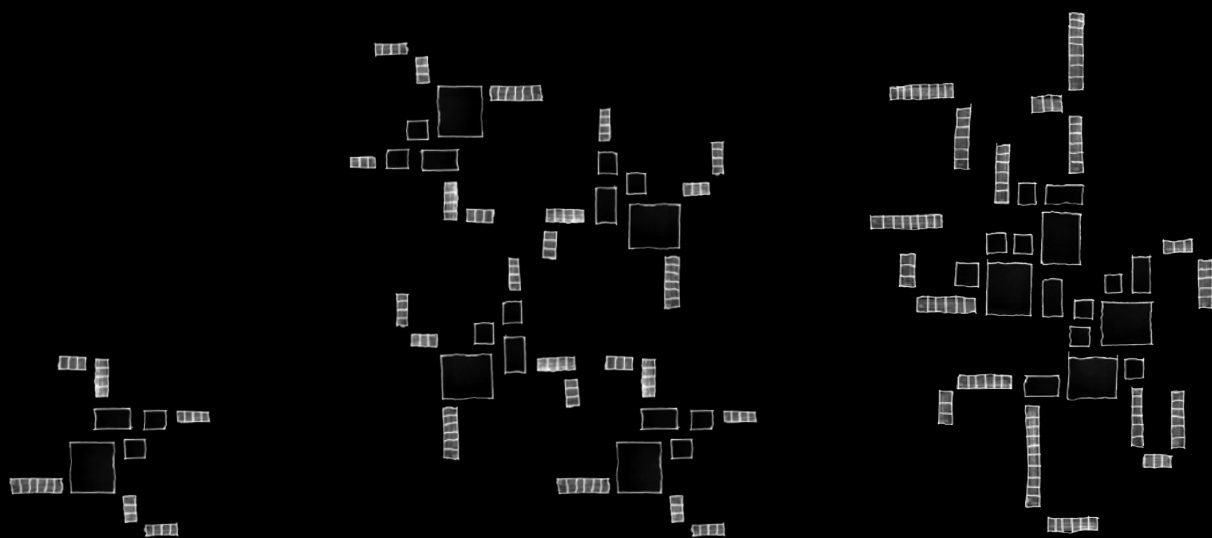


STEM + WEB CONCEPT



This brings together two concepts to avoid the classification and segregation of different groups of inmates. All individual cellblocks are easily accessible from communal activity spaces, like the stem concept. There is a lack of a strong primary circulation and supporting secondary circulation, so there is no defined circulation. The circulation will be determined by the daily routine of the inmates which would result in a centralized primary circulation.

This idea only appears true in the greater web for all inmates. Whether the classification and segregation of inmates has yet to be proven good or bad in all cases, the use of solitary confinement and worsened cell conditions as punishment is prohibited; cell conditions should only change out of protection for the inmate and staff and are limited to changes in furnishings, placement of windows and glazing/door materiality.



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